Request for Proposal

Provider Network Adequacy Assessment

Montgomery Cares

A Public/Private Partnership Program for
Healthcare for Uninsured Adults in Montgomery County, Maryland

RFP Release Date: June 16, 2022

Proposals Due: July 11, 2022 at 3:00 pm EDT

Expected Period of Performance: August 15, 2022 – January 27, 2023EDT

Bidders Informational Q&A Session: June 23, 2022 at 10:00 AM EDT

Zoom Link: https://us02web.zoom.us/j/86579359631?pwd=NDdtbFBtMUtPMnFxZkQ2a0JmdUF4Zz09

Meeting ID: 865 7935 9631 Passcode: 412685

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1. Executive Summary

The Primary Care Coalition (PCC) seeks a vendor to set standards for reasonable access, and perform network adequacy assessments of the primary care and specialty care provider networks for the locally-funded Montgomery Cares program (MCares). The program provides access to healthcare to ~20,000 uninsured, low-income adult residents of Montgomery County, MD.

The goals of this scope of work are to:

1. Define the minimum services, service levels and access standards that the Montgomery Cares primary care (with integrated behavioral health) network of providers (MCares Network) as a whole should provide to enable *reasonable access* for the MCares program-eligible population
2. Determine any need for enhancements or changes to the existing MCares Network composition; including number, type, location, scope of providers and other factors for *reasonable access* that improve the health of the MCares program-eligible population.
3. Understand the root causes of turnover in the MCares patient population and identify ways in which patient retention within the MCares Network may be improved
4. Determine specialties to include in the Montgomery Cares specialty care network (Project Access Network) that provide *reasonable access* to specialty care for the MCares patient population. Set capacity targets for each specialty. Review other non-insurance healthcare access programs across the U.S. for access models for high cost care, specifically oncology, joint replacement and dialysis.

The perspective of currently active and inactive MCares eligible patients is of utmost importance to the definitions of *reasonable access*, and to understanding factors in patient turnover. The vendor must have capability to collect input directly from current and former MCares patients using statistically valid mechanism(s). The vendor must have experience working with low-income populations, especially in which the majority do not speak English as a first language.

2. Background and Montgomery Cares Program Description

a. Montgomery County, MD

Montgomery County, MD is home to a diverse population of more than one million people. Approximately 19% of the population is black or African American, 15% Asian, 43% white, 12% other races, and 11% report more than one race. More than one-third of the County's population is foreign born. The County is rapidly aging; one in five residents will be age 65+ by 2030. Although the County is generally wealthy, it is home to one of the larger number of low-income, uninsured people in the state). Most of these individuals have visa or documentation statuses that preclude eligibility for all state and federally funded insurance programs.

Decades ago, Montgomery County recognized the importance of providing equitable access to healthcare for low-income, uninsured residents. County government, through its Department of Health and Human Services (DHHS), have invested in a portfolio of healthcare programs that serve low-income residents who are ineligible for state and federal healthcare programs. These programs are implemented through locally developed networks of providers. The five healthcare

for the uninsured programs are: Montgomery Cares (adults age 18+); Care for Kids (children from birth to age 19); Maternity Partnership Program; Healthcare for the Homeless; the County Dental Program.

The County government provides core funding, and the programs leverage additional financial and in-kind contributions from the philanthropic community, hospitals, and individual health care providers.

This RFP addresses network adequacy for the Montgomery Cares program only.

b. Montgomery County, MD DHHS Public Health Services

The County DHHS's Public Health Services (PHS) department oversees the MCares program, including setting policy on participant eligibility and primary care network participation. DHHS PHS oversees an annual MCares budget that includes more than $5M in core County funding for primary care and more than $350,000 for specialty care. Although MCares has been a fee-for-service program, DHHS PHS is considering a design to shift to a value-based care model. The MCares program already has a strong clinical quality measurement program.[1]

c. PCC

PCC is a 501c3 nonprofit, founded in 1993 and headquartered in Silver Spring, MD. Our mission is to improve the health of vulnerable individuals and families by building partnerships and strengthening systems. PCC administers multiple programs that coordinate high quality health services for uninsured individuals and families, and communities with risk factors for poorer health outcomes. PCC builds networks for access to care by underserved or uninsured individuals, serves as a central referral hub for medical and medicine access, facilitates adoption of system-wide improvements (e.g., PCMH, behavioral health – primary care integration), and provides technical assistance to improve quality of care, reduce health disparities and enhance the sustainability of safety-net providers. PCC-administered programs are collaborations; partners include safety-net clinics and FQHCs, hospitals, specialists, national prescription assistance programs, local government, and social service agencies.

PCC is the coordinating entity for the Montgomery Cares program. With funding from the County, PCC develops the provider networks for primary and specialty care; oversees provider reimbursement, quality assurance and quality improvement; and supports medicine access though group purchasing and prescription assistance programs.

d. Montgomery Cares (MCares)

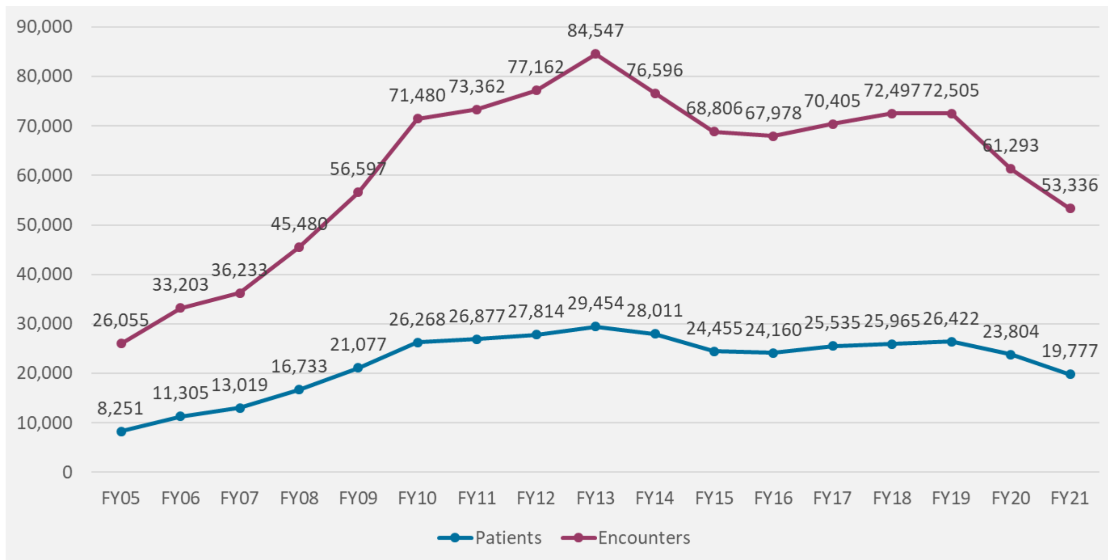
The MCares program began in 2005 and serves adults age 18 and older. At its peak in 2013, prior to the implementation of the Affordable Care Act (ACA), the MCares program served

[1] See the FY2019 report for more information: https://www.primarycarecoalition.org/uploads/1/1/8/3/118354866/q_clinical_measures_annual_report__fy_2019_2-4-20.pdf

almost 30,000 uninsured adult county residents through nearly 85,000 primary care encounters. The ACA, and then the pandemic, have reduced utilization in recent years (Exhibit 1).

Adults 18 and older are MCares-eligible if they 1) demonstrate county residence; 2) live at or below 250% of Federal Poverty Level (FPL); and 3) are not enrolled in AND are ineligible for health insurance - including Medicaid, Medicare, Qualified Health Plan, Employee Sponsored Coverage or Commercial Insurance.

Exhibit 1:
Montgomery Cares Unique Patients and Primary Care Encounters by Year



Fiscal year 2021 (FY21) data show that 79% of the MCares patient population speak Spanish; 41 languages are spoken across this patient population. Seventy-eight percent of patients are between the ages 30 and 64, 62% are female, 67% identify as Hispanic/Latino, and 66% report family incomes at or below 100% FPL.

Based on data from 2015 to 2021, approximately half of the unique MCares patients with a primary care visit in any year utilize the primary care network in the following year; even fewer have a visit with each subsequent year (Exhibit 2). Despite this, the total number of unique patients in any given year has remained fairly consistent year-to-year. Additional data show those who continue to have visits within the primary care network over multiple years are more likely to have chronic conditions and/or be on multiple medications.

primary care coalition

Exhibit 2: Patient Retention

	Patient Retention: Unique Patients Who Have a Primary Care Visit in Subsequent Years							
	2014	2015	2016	2017	2018	2019	2020	2021
2014	0	0	0	0	0	0	0	0
2015		23947	11200	7113	4984	3735	2645	1994
2016			23609	12293	7706	5455	3714	2749
2017				24741	13020	8243	5257	3721
2018					25345	13524	7620	5067
2019						26838	12416	7247
2020							21544	10491
2021								19203

THE MCARES NETWORK (PRIMARY CARE WITH INTEGRATED BEHAVIORAL HEALTH)

MCares-eligible patients can schedule appointments at any of 10 independent, non-profit clinic organizations [“clinics”] that comprise the MCares primary care network and deliver services at more than 30 locations across the county. Most patients remain with the clinic organization where they initially receive care; less than 3% seek care at a different clinic organization each year.

The clinics are vastly different in size and structure: three of the 10 are Federally Qualified Health Centers (FQHCs), one clinic is run by a hospital system. In addition to serving MCares patients, nine accept Medicaid, eight accept Medicare, and seven accept commercial insurance. The smallest clinic serves under 1,000 patients on an annual basis while the largest serves more than 30,000. Some clinics see MCares patients almost exclusively, while MCares accounts for less than 10% of all patients at the largest FQHC.

All 10 primary care clinics offer on-site behavioral healthcare (BH), following an integrated or collaborative model.[2] Onsite BH staff assess and treat BH diagnoses that can be managed in a primary care setting, mostly anxiety and depression. Staff may also provide case management and referral for social service needs. For acute or intensive BH needs that cannot be managed in a primary care setting, staff refer patients to outside agencies. All clinics have limited access to psychiatry for provider case consults; some clinics can provide psychiatry appointments for a limited number of patients. Some clinics employ their own BH staff, while some partner with external providers to place the staff onsite. Five clinics’ onsite BH staff are part of PCC’s BH collaborative care team, which partners with MedStar Georgetown University Hospital for psychiatric consults and limited patient panels.

MCares program policy permits clinics to charge no more than a $35 copay for each primary care visit for patients with family incomes at or below 100% FPL. Some clinics charge additional fees

[2] Kaltman S, Pauk J, Alter CL. Meeting the mental health needs of low-income immigrants in primary care: a community adaptation of an evidence-based model. *Am J Orthopsychiatry*. 2011;81(4):543-551. doi:10.1111/j.1939-0025.2011.01125.x

for ancillary services such as labs and imaging. MCares program policy does not currently set co-pay caps for patients with family incomes between 100 and 250% FPL.

See Appendix A for a list of participating clinics and locations; see Appendix B for the minimum set of healthcare services that all clinics must provide to participate in the MCares network.

SPECIALTY CARE NETWORKS

All clinics refer a majority of patients who need specialty care consults to two networks: 1) Project Access and 2) the Catholic Charities Health Care Network (CCHCN). These two networks share a referral platform and collaborate closely. Both have constrained or even no capacity for some specialties.

Project Access[3]: PCC administers the Project Access specialty care network, recruiting and contracting with a broad range of specialists, triaging patient referrals from the MCares clinics, ensuring needed labs are ordered by the primary care providers, making the specialty care appointments, and processing specialty care provider claims. Project Access serves only patients referred from the 10 MCares clinics.

The majority of specialists contracted with PCC in the Project Access network provide services at discounted prices, some accept Medicare rates, and a minority serve pro-bono. Project Access has relationships with hospitals for pro-bono operation room time and anesthesia, should the specialty care consult lead to a need for surgery. Project Access offers very limited access to joint replacement and oncology care and treatment, and offers no dialysis services.

CCHCN: CCHCN is a pro-bono specialty care network run by Catholic Charities of the Archdiocese of Washington. CCHCN is not specifically for the MCares program; it accepts referrals from over twenty safety net providers in Washington, DC, and Montgomery and Prince George's Counties in Maryland. CCHCN provides some access to surgery through its relationships with MedStar Georgetown and Sibley hospitals.

Specialty Care Access through MCares Primary Care Clinics: In addition to the specialty care available through Project Access and CCHCN, a limited number of specialty care consults are available onsite at clinics within the MCares primary care network. For example, a clinic may have a nephrologist available on a monthly basis, or other specialists that have varying availability month-to-month. Some clinics allow referrals from other clinics to their see their onsite specialists, while others reserve their specialists' time for their patients only. Some clinics have formed direct referral relationships with specialists in the community.

[3] Project Access is a model for specialty care for the uninsured that has been implemented, with substantial variation and by many different entities, in many part of the U.S.

3. Scope of Work

This RFP seeks to identify a vendor to:

1. Determine Network Adequacy Standards for the MCares Network (primary care with integrated behavioral health services)
2. Conduct a Network Adequacy Assessment for the MCares Network (primary care with integrated behavioral health)
3. Conduct an analysis of factors impacting patient retention rates in the MCares Network (primary care with integrated behavioral health), and factors related to Network Adequacy
4. Determine breadth of the Project Access specialty care Network; set Capacity Targets for each specialty recommended to be in-network; research existing models for providing access to very high-cost specialties.

Each component of the scope of work is described in detail below.

a. Network Adequacy Standards for the MCares Network (primary care with integrated behavioral health)

Goal: To define the minimum services, service levels and access standards that the MCares Network as a whole should provide to enable *reasonable access* to primary care with integrated behavioral health care for the MCares-eligible population. Reasonable access should consider MCares patient expectations of primary care, accessibility (e.g. geography, physical accessibility, hours of service availability, affordability), and cultural competence. Network Adequacy Standards should be defined such that the MCares Network is designed to decrease population-level health disparities and improve the health of the MCares-eligible patient population.

Deliverable Content: Clearly defined MCares Network Adequacy Standards that incorporate:

1) Definition of provider types that should be included in the MCares Network (if any additional types are needed beyond primary care with integrated behavioral health)
2) Minimum standards for providers that participate in the MCares Network regarding services, patient experience, accessibility and cultural competence. Minimum standards may be distinguished per provider type, should vendor determine reasonable access would be enhanced by the addition of provider types to the MCares Network beyond primary care with integrated behavioral health.
3) Any other recommendations for MCares network design to address reasonable access for the MCares-eligible population.

The vendor shall consider the following when developing the MCares Network Adequacy Standards deliverable:

i. Network and Provider Standards

- Network standards shall be clearly defined and allow for assessment and decisions by PCC and/or DHHS as to whether to increase providers or expand provider types in the MCares Network. Participating provider minimum standards shall be defined and

described such that the standards can be included in MCares Network provider contracts, and assessed for compliance by PCC or an external auditor.

- The vendor shall update and enhance, if needed, the current minimum service standards for primary care providers to participate in the MCares Network.
- Minimum provider participation standards shall be detailed by provider type if vendor determines a single standard is not sufficient (e.g., if vendor recommends the MCares Network include additional provider types, a single standard may not apply across all provider types).

ii. **<u>Patient Expectations of and Need for Primary Care Services</u>**

- Standards for the services provided in the MCares Network, shall consider what the diverse MCares-eligible patient population states they expect, need, and prioritize from the MCares Network (considering multicultural expectations of primary care with integrated behavioral healthcare).
- Standards for ancillary resources available shall consider needs for network primary and integrated behavioral health providers to deliver and maintain continuity of high-quality primary care and integrated behavioral healthcare that improves individual patients' health and addresses population-level health disparities.

iii. **<u>Accessibility, Cultural Competence and Accommodation</u>**

- Standards for patient-to-provider ratios
- Standards for types of modalities available to deliver medical care
- Standards for timeliness of appointments, ease of scheduling an appointment, breadth of appointment hours, proximity of and ease of travel to provider locations
- Standards for providing culturally competent care to MCares eligible patients of varying racial, ethnic, linguistic, and cultural groups, the LGBTQIA+ community, and religious sectors
- Standards for physician-patient communication via available patient access/support portals
- Standards to meet patient-expressed access needs for urgent services, telehealth
- Standards that support access and accommodate different levels of health literacy for non-English speaking patients, and patients with physical or developmental/intellectual disabilities
- Standards regarding availability of materials, information, and dissemination of information about the MCares program and the MCares Network (e.g., program information and clinic information) that is readily available to the eligible population in culturally and linguistically welcoming modes, and consistent with how the population seeks information and referrals for services

iv. **<u>Equity in Affordability.</u>**

- Considerations regarding equitable variation in costs to MCares patients for the same services across the primary care clinic. Defined income bands for the MCares-eligible population are a) 100% FPL and below, b) 101%-250% FPL.

b. Network Adequacy Assessment for the MCares Network

Goal: Determine any needs for enhancements or changes to the existing MCares network composition, number, and type of providers, location of providers, scope of providers, and other factors for reasonable access to best serve MCares patient population.

Deliverable Content:

1) An assessment that summarizes any MCares Network gaps, deficiencies, or barriers to reasonable access to primary care with integrated behavioral health for the MCares-eligible population, per the MCares Network Adequacy Standards, with prioritization and rationale for the prioritization.
2) Actionable recommendations to address MCares Network gaps, if any, where the recommended actions could reasonably be within the authority or influence of Montgomery County DHHS and/or PCC (e.g., adding providers, locations or provider types, updates to standards for provider network participation, funding, technical assistance to providers). Recommendations can consider expansion of the existing primary care with integrated behavioral health provider network (including but not limited to inclusion of centralized telehealth services; private, urgent care, home-visiting, or additional safety-net providers). However, a recommendation for retaining the MCares network design as it is currently designed is also an acceptable conclusion should it meet the Network Adequacy Standards.
3) Recommendations for enhancements/changes, if needed, to the current required essential services list for MCares participating providers to ensure a standard of essential services that meets reasonable access standards (see Appendix B).
4) A tool with which DHHS and/or PCC can update or re-assess network adequacy for reasonable access in interim years between external network adequacy studies.

*NOTE: The Network Adequacy Assessment does **not** include a detailed assessment of each existing MCares Network provider's compliance with Provider Participation Standards.*

c. Analysis of patient retention rates in primary care, and factors related to Network Adequacy

Goal: Patient retention with a primary care provider is a cornerstone of prevention and wellness, and chronic disease management. Patient retention within primary care is also key to value-based care payment models. The goal of this activity is to understand the root causes of MCares patient turnover and identify ways in which patient retention may be improved.

Deliverable Content:

1) An analysis of the factors that influence patient year-to-year retention in the MCares Network and those factors that contribute to the approximately 50% annual turnover in unique patients4

[4] PCC has access to the full EHR (eClinicalWorks) data for six of the 10 primary care clinic organizations, from 2014 to the present. Analysis of these data, included in summary in RFP Section 2.d, will be shared with the awardee.

2) Recommendation for patient retention target(s), and how to achieve target(s).

Vendor activities shall include:

- Summary of external literature on retention specific to safety-net populations.
- Comparison of retention rates in the MCares primary care population and national averages or other metrics, for safety-net and non-safety-net populations.
- A recommendation for MCares patient retention target(s) based on the literature
- Assessment of whether MCares primary care patient retention is reasonable given comparative data; if not currently reasonable, define the gap from target(s).
- Gathering of MCares patient (current and former) and current MCares Network provider perspectives on factors that affect MCares patient retention year-to-year. PCC, if requested, can facilitate scheduling of interviews with providers and/or clinic staff. The Vendor is fully responsible for these gathering perspectives from a reasonable sample of current and former MCares patients.
- Identification of factors that impact MCares patient retention year-to-year, including those related to MCares network adequacy and those unrelated (e.g., transience of patients' place of residency).
- A prioritization of factors on which to focus to move MCares patient retention towards target(s), if not already at target(s).

d. Network and Capacity Standards for Project Access Medical Specialty Care

Goals: To determine specialties to include in the Project Access specialty care Network[5] that enable *reasonable access* to specialty care for the MCares patient population; to set Adequate Capacity Targets for each specialty recommended to be in-network; and to understand factors that are barriers to access to Project Access specialty care for MCares patients and their referring MCares Network primary care providers. This scope of work will inform and prioritize Project Access provider recruitment efforts, provide data useful in advocacy and grant submissions that seek additional specialty care funding, and improve the Project Access specialty care referral process thereby reducing barriers to care for MCares patients and their referring primary care providers.

Deliverable Contents:

1) Reasonable Access: Vendor shall recommend the set of specialty care services to be included in the Project Access specialty care Network that provides reasonable access for the MCares population and reasonable referral options for primary care providers in the MCares Network, considering MCares is a safety-net, locally funded healthcare access program for uninsurable adults.

[5] PCC will provide the vendor with the full list of medical specialties available under Project Access; PCC will connect the vendor with CCHCN to obtain a list of specialties available under CCHCN.

- The vendor shall delineate the rationale for included specialties and ancillary services (e.g. other non-insurance health care access programs around the country commonly include the specialty; the specialty is an essential referral pathway for primary care providers to continue managing care; the specialty is considered a reasonable access requirement and is not regularly available - or available in sufficient quantity - through other specialty care pathways available to MCares patients).
- In addition to medical specialties, the vendor shall consider and make recommendation whether reasonable access includes sleep studies and CPAPs, eye exams and eyeglasses, hearing exams and hearing aids and, if so, standards of reasonable access for these.
- For the very high cost specialty services of joint replacement (inclusive of the ortho durable medical equipment), oncology, and dialysis, vendor must conduct a review of non-insurance healthcare access programs for adults around the country. Vendor shall develop a list of the programs that provide joint replacement, oncology services, and/or dialysis services at an affordable cost to the uninsured patient on a non-emergent basis, with a brief summary of the service offering. Vendor shall provide a recommendation as to whether joint replacement, oncology and/or dialysis on a non-emergent basis should be included services under a reasonable access standard in the Project Access specialty care Network. If recommended for inclusion, vendor shall provide contact information for the non-insurance programs that provide these services to their uninsured adult patients that Project Access might emulate regarding design and costs.

2) Network Capacity: The vendor shall recommend a benchmark or target for MCares population-to-provider ratios, appointment slots, or days/weeks/wait-time to appointment for each specialty recommended for inclusion in the Project Access Network, that would achieve reasonable access for MCares patients. These must be quantitative benchmarks or targets by which DHHS and PCC can assess improvement over time towards specialty care network capacity adequacy.

3) Project Access Process Improvement Recommendations: From interviews conducted by vendor with MCares patients[6] who have utilized specialty care through Project Access, with primary care providers or referral specialists in MCares clinics, with PCC Project Access staff, and with Project Access network participating providers (to the extent possible, most are too busy), vendor shall:
    - Summarize and prioritize key areas of the patient experience that pose barriers to specialty care access (e.g. administrative process, affordability, transportation, location, and language barriers).

[6] The vendor can include questions related to specialty care in interviews with MCares patients and primary care providers as part of the MCares Network Assessment.

- Summarize barriers to obtaining needed specialty care for MCares patients through Project Access (e.g. administrative process, time-to-appointment, available specialties).
- Summarize reasons Project Access specialty providers remain in the network, decline to participate or exit the network (e.g., care delivery, administrative challenges).
- Make recommendations on how to address barriers and challenges.

These deliverables are specific to the network of specialty care providers contracted under Project Access, as this is the network over which PCC has the ability to make enhancements, although vendor must consider the other specialty care access pathways (e.g. CCHCN, specialty care via primary care clinics) as the environment in which Project Access operates.

4. Considerations for Conducting the Scope of Work

In conducting the Scope of Work, the vendor shall consider the following:

- The vendor's research of access standards must look at non-insurance healthcare access programs and Medicaid, preferably Maryland Medicaid. Although other insurance programs can provide reference, the vendor's proposed definitions and standards for reasonable access must address that MCares is a safety-net, locally funded healthcare program that serves a low-income, culturally and linguistically diverse patient population. As a locally funded program, the overall MCares program benefits are broad but will not be not as extensive as an insurance product such as Maryland Medicaid.
- The perspective of currently active and inactive MCares eligible patients is of utmost importance to the definitions of reasonable access. The vendor must collect information directly from patients and former patients on the experience of and need for primary care to inform definitions and standards. Definitions and expectations for care may differ greatly among the MCares patient population.

5. Contract Required Activities

The vendor shall propose activities and a work plan to achieve the Contract Deliverables. At a minimum, these activities must include:

- Collection of current and former MCares patient input using statistically valid mechanism(s) to understand:
- Patient expectations for and experience of access to primary care, including integrated behavioral healthcare, and specialty care through the specialty care networks.
- What factors support or reduce patient engagement with their primary care providers/clinic.
- What factors contribute to the approximately 50% patient turnover per year.

Whether through surveys, focus group discussions or other mechanisms, the vendor must provide options to participate in English, Spanish, and other languages that will gain representative samples of patients from the 10 clinics [e.g. French, Amharic, Portuguese, Chinese, Vietnamese]. To accommodate the

population's limited literacy level, there must be options to provide input verbally; this does not preclude use of written methods.

The proposed mechanism(s) to gather patient input must consider that this is a low-income, uninsured population, the majority of whom do not speak English as a first language. Fear driven by legal residency status or visa issues is common, and patients may have frequent changes in their contact information.

a. Mechanisms to gather input on ancillary resource and referral needs from a sample of MCares Network providers.
b. On-site visits to at least three (3) clinics. This must include at least one FQHC, one non-FQHC run by a large clinic organization, and one clinic with at least 80% of its patient population in the MCares program.
c. Inventory of the current services and access at each primary care clinic in MCares Network. The inventory shall, at minimum, document the following for each clinic location and/or organization:
   - Address of location(s), number of exam rooms
   - Healthcare services available onsite
   - Healthcare services available via outside referral
   - Number of clinical hours of service available weekly, for primary care, behavioral health, and onsite medical specialty care. If vendor deems relevant to the overall network adequacy assessment, collect provider characteristics including gender, race, ethnicity, languages spoken
   - Operating days of the week and hours for patient care
   - Numbers of patients served overall, by service area if relevant, and percent of those patients in the MCares program
   - Whether clinic performs onsite clinical breast exams, cervical cancer screening and colon cancer screening (e.g. FIT, Cologuard), or refers out for these services
   - Appointment factors including:[7]
   - Average time-to-next appointment by service type, for new and existing patients, by service area as relevant
   - Ease of scheduling an appointment including average time to reach an appointment scheduler by phone; availability and ease of electronic or online self-scheduling; elapsed time to schedule an appointment; burden of documentation/forms required of patient to access an appointment
   - Physical access factors including public transport accessibility, accessibility of clinic space and exam rooms for handicapped and developmentally disabled, availability of audio and video telehealth appointments
   - Direct costs to patients by income level, by service area, and ancillary costs such as labs
   - Non-medical access factors such as accommodations for non-English languages (including sign language), culturally competent care to serve the diverse population (e.g. competence related to race/ethnicity, religion, sexual orientation and gender identity)
   - Proximity of clinic location to the home addresses of MCares patients served at that clinic

[7] The vendor may wish to consider, but is not required, to conduct "secret shopper" activities to evaluate accessibility, ease, and elapsed time for patients to schedule appointments.

PCC conducted a subset of this inventory a few years ago, and will supply those results to the awardee, if requested. For six of the 10 primary care clinic organizations, PCC can also supply to the awarded vendor:

- The list of providers, credentials and part-time vs. full-time status
- Analysis of the proximity of the patient home address (per EHR) to the location of the clinic the patient utilizes

6. Timing and Communications

From the start of the contract, PCC shall designate a primary point of contact (POC) for the awardee. Vendor and PCC POC shall hold a project progress meeting (virtual) at least every two weeks. A representative from DHHS PHS may also attend.

PCC's POC will:

- Connect vendor to MCares primary care clinic contacts, schedule site visits (vendor can schedule directly if preferred).
- Supply additional MCares program background and data; connect vendor to PCC data analytics team for review of patient retention analysis and other pertinent data.
- Connect vendor to the PCC Specialty Care Clinical Manager (Project Access), and CCHCN.
- Address patient privacy issues, if any, related to scope of work. Although PCC is not a Covered Entity, PCC is a Business Associate of DHHS and each MCares clinic organization. Vendor will be required to enter into a Subcontractor Business Associate Agreement with PCC.
- Review proposed mechanisms for each contract required activity prior to its implementation. Provide feedback to strengthen, as needed. Vendor retains control over final mechanisms and responsibility for achieving contract outcomes.

The vendor will:

- Propose a timeline for the contract required activities and submission of deliverables. PCC prefers that all contract activities be completed within 5 months of contract award, and all deliverables completed – inclusive of PCC / DHHS review and comment period – by six (6) months from contract award. The vendor may propose an alternate timeline, with justification.
- Develop a work plan, which must include 2 weeks for PCC / DHHS to review and provide comment on each deliverable plus time for vendor to revise and finalize.

Regular communication between vendor and PCC POC throughout the project is intended to limit any significant need for deliverable revision. In addition, the vendor must meet the following milestones:

Not Later Than, from Contract Effective Date:	Milestone
End of Month 1	• Selection of clinic sites to visit, scheduling in progress • Full plan for gathering patient input presented to POC, with any requests for PCC assistance or data.
End of Month 4	• On-site visits to at least three MCares clinics completed. • Inventory of current services and access at each MCares primary care clinic completed.

7. Proposal Submission

The following are key dates for this proposal:

June 16, 2022	Release of RFP
June 23, 2022 10:00 AM EDT	Bidders Informational Webinar
July 11, 2022 3:00 PM EDT	Deadline for email receipt of full proposals
August 1, 2022	Award Announcement
August 15,2022 – January 27, 2023	Period of Performance

The Proposal must include the following sections. Total proposal length shall not exceed 20 pages.

1. **Cover Letter**. Submit a cover letter that includes the following:
   i. Legal Name and address of Business or Consultant
   ii. Designated Point of Contact for proposal (name, title, phone, email)
   iii. FEIN or TIN (leave blank if Sole Proprietor or Independent Consultant utilizing an SSN)
   iv. Statement attesting [Proposing Entity] is in good standing, is current on its state and federal taxes, and is not currently debarred or suspended from conducting business with any U.S. local, state or federal entity.

2. **Organizational Experience and Credentials.** Using examples of past performance, describe your firm's experience, credentials and capacity to carry out the scope of work and create meaningful deliverables, including:
   - Experience/understanding of low-income, immigrant and/or underserved patient populations.
   - Experience designing and conducting user or patient satisfaction/ experience data collection in populations with multiple languages and cultures.
   - Analytical and evaluation capabilities including quantitative and qualitative analysis.
   - Experience with healthcare network adequacy assessments.

If subcontractors will be utilized for significant areas of work, name the subcontractor(s), their designated scope under this proposal, and describe the experience and capacity of the subcontractor(s).

3. **Approach to Scope of Work**. Describe your firm's overall approach and work plan to carry out this work including, but not limited to:
   - Approach to developing the network standards
   - Approach to engaging each of the stakeholder groups. Be specific on the plan for addressing the challenges of engaging the low income, immigrant, non-English primary language patient groups; and plan for engaging with previous patients of the Montgomery Cares program who have not accessed the Montgomery Cares primary care network in two years or more.
   - Approach to evaluating the turnover in patient retention each year.

- Approach to project management and communication.

4. **Work Plan or Timeline.** Include a work plan or timeline of the major contract activities and deliverables. Discuss potential challenges to meeting the timeline. Present requests, if any, for alterations in the project timeline as described in the RFP.

5. **Personnel Capacity.**
   - Describe the skills and structure of the team that will conduct the activities of this project.
   - Provide bios or resumes of key staff
   - Detail which activities will utilize subcontractor (s), and provide brief capacity and experience summary information on known subcontractors.
   - Describe the level of effort that will be dedicated to this project.

6. **References.** Provide three (3) references of past or present clients of your firm for which similar work has been or is in the process of completion. If a subcontractor will conduct a significant area of the scope work, provide two (2) references for your firm and one (1) reference for each significant subcontractor. Provide in the format:

   Reference Person's Name

   Title and Organization

   Phone Number and email

   Brief description of the relevance to this project (3 sentences or less)

7. **Budget**. Project Budgets must be presented with details per the sample budget below. The vendor must provide one project budget that encompasses the activities for Scope of Work 3.a, 3.b, and 3.c, and a separate budget for the incremental work needed to accomplish Scope 3.d (Network and Capacity Standards for Project Access Medical Specialty Care).

Personnel Costs (Employees)		Estimated Hours	Cost
	Key Staff (bios in proposal)		
	Other Staff		
Consultants/Subcontractors			
Software, data, Technology			
Travel			
Other Costs			
G&A, Indirect and/or Fee			
	TOTAL COST		

The vendor must provide a brief narrative for each major budget line item. All funding of this scope of work is contingent upon PCC having allocation of funds from DHHS. The vendor may not charge for costs incurred before the effective date of the contract, nor after the termination date of the contract. The Bidder assumes all costs of preparation of the proposal, any addendums thereto and any presentations or

further communication necessary for the proposal process. PCC may reject all proposals should none adequately address the scope of work.

The proposal must be submitted at or before the deadline. Proposals that are late, incomplete or in formats that do not comply with the requirements will not be considered.

Use the following email address to submit questions about the RFP. Submit proposals, in .pdf format to this email address as well: info@primarycarecoalition.org

You will receive confirmation of receipt of your submission.

Any amendments to the RFP and answers to common bidder questions will be posted to the URL below. It is the bidder's responsibility to check the webpage for any updates: https://www.primarycarecoalition.org/montgomery-cares-network-adequacy-study.html

Award Basis:
The criteria to be used to evaluate each proposal is listed below in descending order of importance.

1. Applicant demonstrates the understanding of and a detailed, implementable approach to perform all aspects of the scope of work.
2. Applicant proposes a project team that has brings experience and knowledge from similar engagements, and demonstrates adequate staffing, organizational capacity, project management and communications plans to meet the requirements of the scope of work within appropriate timelines?
3. Applicant demonstrates relevant successful prior experience with similar scopes of work.
4. Applicant's work plan is realistic.

Proposals will be ranked based on the criteria above.

Recognizing vendors may have different methodologies and approaches to the RFP scope of work, the award will not be on lowest cost. Budgets will be evaluated for reasonableness of cost given the effort and approaches described in the proposal narrative, and only those determined to be of reasonable cost for the effort and approach described will have their proposals continue in the selection process.

Selection will be made based on the most advantageous ranking of proposals and budgets.

Appendix A: Montgomery Cares Participating Clinic Organizations and Locations

The 10 clinic organizations participating in the MCares Network include:

- Catholic Charities, Medical
- Pan Asian Volunteer Health Clinic, service of Chinese Culture and Community Service Center
- CCI Health & Wellness Services (FQHC)
- Kaseman Health Clinic, service of Community Reach of Montgomery County
- Holy Cross Health Centers, service of Holy Cross Health (a Trinity Health member)
- Mary's Center (FQHC)
- Mercy Health Clinic
- Mobile Medical Care (FQHC)
- Muslim Community Clinic, a service of Muslim Community Center
- Proyecto Salud

Information on locations can be found at:

https://www.primarycarecoalition.org/findaclinic.html

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Appendix B: Montgomery Cares Essential Services

All clinic organizations in the MCares Network are required to provide a minimum set of healthcare services (see table, below). The specific amount and level or intensity of services may vary by health center based on factors such as provider staffing and collaborative arrangements. Services should be provided in a culturally and linguistically appropriate manner based on the population served.

Service Category	Minimum Service Description	Access Level
General Primary Medical Care	• Assessment, diagnosis, and screening • Education and treatment • Referrals to medically necessary services • Any needed follow-up from each of the services described above	Onsite access at all clinics
Diagnostic Laboratory Services	• Specimen collection • Laboratory interpretation of the result; and communication and interpretation of lab results to be given by the clinic provider to patient; lab result must be maintained in patient record • Tests include Clinical Laboratory Improvement Amendments (CLIA) waived tests, moderate complexity & high complexity lab tests (typically provided by a certified reference lab). Providers may select on site testing appropriate for their populations	Onsite access with conditions[8]
Diagnostic Radiology	Plain medical films (e.g., x-ray)[9]	
Screenings	• Breast, cervical, and colorectal cancer • Communicable disease • Cholesterol • Retinal eye exams for diabetic patients[3]	
Family Planning	Counseling and referral for available reproductive options that may include condoms, oral contraceptives, implantable or injectable hormonal contraceptives, barrier methods, IUD and natural family planning. May include management/treatment and procedures for a patient's chosen method and condition	Onsite access with conditions[10]

[8] Interpretation of results must be conducted at clinic sites; specimen collection may be conducted onsite or off site

[9] Access via referral-only is sufficient

[10] Providers who are prohibited from offering family planning services may have a structure in place to link patients to additional counseling at other providers rather than solely onsite.

Service Category	Minimum Service Description	Access Level
Immunizations	For adults, the CDC recommends a vaccine schedule available at this link: www.cdc.gov/vaccines/schedules/hcp/adult.html The CDC recommendations for adult vaccines include: (1) Annual influenza, (2) Tetanus, diphtheria, pertussis (Td/Tdap), (3) Human Papilloma Virus (HPV), (4) Measles, mumps, rubella (MMR), (5) Zoster, (6) Pneumococcal, (7) Other immunizations based on health condition and risk factors	Onsite access with conditions[11]
Gynecological Care	• Pelvic and breast exams • Cervical cancer screening • Evaluation and treatment of menstrual, reproductive history, and gynecological symptoms	Onsite access at all clinics
Pharmaceutical Services	• Prescribing of appropriate medications • Dispensing and tracking of medication as required by state and federal law	Onsite access with conditions[12]
Case Management/ Care Coordination	• Assessment of factors affecting health (e.g., medical, social, housing, educational, food insecurity, domestic violence, etc.) • Information/referral to patient based on identified needs and periodic follow-up of services	Onsite access at all clinics[13]
Eligibility Assistance	• Application assistance/counseling for Montgomery Cares and other health insurance coverage • Provider can accept patient supporting documents to establish eligibility to be transmitted to the County Office of Legibility and Support Services. This includes eligibility assistance for Montgomery Cares if seeking specialty care; Medicaid; ACA coverage; Veteran's benefits; Special Supplemental Nutrition Assistance Program (food stamps); Temporary Cash Assistance, etc. Clinics refer to appropriate public service as needed.	Onsite access at all clinics
Health Education	• Education regarding condition/diagnosis • Self-management education • Education regarding the appropriate use of health services	Onsite access at all clinics and/or referrals
Interpretation and Translation	Timely availability of competent medical translation (written) and interpretation (oral). Services may include written material designed for low-literacy, written materials in multiple languages, access to certified medical interpreters, bilingual providers trained/certified in medical interpretation, and/or language telephone line	Onsite access at all clinics

[11] Services may be provided via referral based on availability of immunizations

[12] Prescribing must be on-site; dispensing and tracking of medications may be conducted by an outside organization

[13] Contingent upon funding for staff at clinics for psycho-social case management

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Service Category	Minimum Service Description	Access Level
Behavioral Health (Screening)	• Routine screening for depression, anxiety, tobacco use and risky alcohol or drug use as part of a primary care visit • Referral to appropriate services for patients based on screening	Onsite access at all clinics
Behavioral Health (Diagnosis and Basic Treatment)	• Diagnosis and treatment of common, moderate mental illnesses such as depression and anxiety • Diagnosis and provision of brief interventions and referrals for treatment for alcohol and substance related problems • Referral to specialized behavioral health services (usually not on site) for treatment of severe mental illness and/or active alcohol/substance abuse disorders	Onsite access at all clinics and referral for severe cases
Nutrition	• Nutrition education and counseling • Interventions to enhance knowledge and impact behaviors relating to healthy eating, nutrition, and health; may include medical nutrition therapy	Onsite access at all clinics and/or referrals
On Call Coverage for Emergencies During After Hours	During the health center's regularly scheduled hours: • Health center has clearly defined processes and arrangements to respond to patients presenting with urgent/emergent and to transfer patients to a more appropriate setting for additional health care services After the health center's regularly scheduled hours at a minimum: • Provision of telephone access through clearly defined written arrangements to a qualified professional to assess a patient's need for emergency medical care and, if appropriate, refer to provider/facility to meet patient's emergency needs • Provision to facilitate follow-up by the health center for patients accessing after hours coverage	Onsite access at all clinics[6]