

Connecticut Department of Public Health

Request for Proposal (RFP) July 2012

RFP # 2013-0901

The Connecticut Cancer Integrated Health Screening Program (CIHSP)

The Connecticut Department of Public Health (DPH) Comprehensive Cancer Program is pleased to announce the availability of funds to request proposals from public, private, profit, and non-profit health care providers in Connecticut to participate in the delivery of the Connecticut Integrated Health Screening Program (CIHSP). The CIHSP is the consolidation of the Connecticut Breast and Cervical Cancer Early Detection (CBCCEDP), Connecticut Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN), and the Connecticut Colorectal Cancer Control (CCRCP) Programs. CIHSP was established to support greater community involvement and efficiency in cancer screenings and diagnostics and cardiovascular risk reduction. The CIHSP will deliver integrated early detection health screening services that **must** include breast and cervical cancer screening for women ages 21-64 with a focus on women rarely or never screened, cardiovascular risk reduction screening for women ages 40-64 who have participated in the breast and cervical cancer program, and colorectal cancer screening for women and men ages 50-64. Twenty-five percent (25%) of all participants screened for colorectal cancer in the CIHSP **must** be men. Program services are targeted to persons who are at or below 250% of the Federal Poverty Level (FPL), are uninsured, or underinsured. Providers may deliver these services directly, via satellite sites, or through providers in subcontractor capacities. All applicants must provide the package of integrated screening services described.

Application Submission

Notice of Intent

Applicants must communicate a written **Notice of Intent** to apply to the DPH by e-mail on or before **4:30 p.m. on August 17, 2012** to michael.fuller@ct.gov.

Cancer Community Advisory Council

A Cancer Community Advisory Council is an effective means of establishing community wide partnerships that will enhance the coordinated approach required to provide and sustain services to CIHSP participants and to support CIHSP participants and their families in adopting and sustaining healthy lifestyles in their communities.

Each funded CIHSP provider will be required to develop, support, and work with a standing Cancer Community Advisory Council. Applicants must identify and submit the potential membership list of their council as part of the application. The membership list needs to contain the names of the members, credentials, agency affiliations, and agency addresses along with letters of support from each potential member.

The Connecticut Integrated Health Screening Program (CIHSP)

The goal of the Connecticut Integrated Health Screening Program (CIHSP) is to reduce the number of deaths associated with breast and cervical cancer, heart disease, and colorectal cancer through early detection screening, rescreening services, and education activities. Early detection allows for the initiation of treatment at earlier stages. Providers must recruit and screen the following participants into the CIHSP:

- Eligible women ages 21-64 years to provide clinical breast examinations, mammograms, Papanicolaou (Pap) tests, diagnostic follow-up of abnormal breast and cervical cancer screenings, and treatment referral services for cancer diagnosis and rescreening according to nationally recommended guidelines.
- Eligible women ages 40-64 years who have received a mammogram/Pap test to provide heart disease assessments of family and medical history, nutrition, physical activity, smoking habits, weight, blood pressure, blood tests that include a lipid profile and glucose, risk reduction counseling, and referrals for medical evaluation and treatment, and one rescreening at the annual office visit for a mammogram/Pap test.
- Eligible women and men ages 50-64 years to provide assessment of candidates for colon cancer risk, colonoscopies, patient navigation services, and access to treatment for cancer diagnosis and rescreening in ten years for participants with no abnormalities or complications. Twenty-five percent (25%) of all participants screened for colorectal cancer must be men.

Funding Sources

The services covered under the CIHSP come from a combination of state and federal sources. The breast, cervical, and colorectal screening services are supported through a combination of state and federal Centers for Disease Control and Prevention (CDC) funds. Heart disease screening services are supported by federal CDC funds.

DPH/Provider Relationships

The DPH will support providers to ensure the delivery of quality and timely health screenings and follow-up services and compliance with state and federal mandates and program guidelines. Providers and subcontractors are required to follow nationally recommended clinical guidelines. DPH oversight includes consultation and technical assistance, trainings, periodic reports, site visits, teleconferences, webinars, and provider meetings throughout the contract period. Providers and subcontractors will be required to attend trainings, submit periodic reports, and participate on teleconferences and webinars.

Availability of State and Federal Funds

A total of approximately \$16.5 million of state and federal CDC funds are available over a five-year period to support this project. Funding of the CIHSP will take place over a five-year period beginning **July 1, 2013 through June 30, 2018** subject to satisfactory provider performance and the availability of state and federal funds.

This RFP is a new and competitive application process. All providers, including those funded under the current Connecticut Breast and Cervical Cancer Early Detection and Integrated Programs, must submit an application in response to this RFP in order to be considered for funding during the fiscal years 2013-2018. All applicants must provide the complete package of integrated screening services. Applications that do not address the complete package of integrated screening services will be removed from the review process.

Eligibility

Applications will be accepted from public, private, profit, and non-profit health care providers in the State of Connecticut. These include federally qualified health centers, clinics, hospitals (including hospital networks), private providers, etc. Applicants need to demonstrate in their applications that they have the capacity to successfully provide the comprehensive package of services that constitutes the CIHSP.

Deadline for DPH Receipt of Notice of Intent

Applicants must communicate a written Notice of Intent to apply to the DPH by e-mail on or before **4:30 p.m. on August 17, 2012** to michael.fuller@ct.gov.

Deadline for DPH Receipt of Proposals

Proposals must be received in person or by US Mail postmarked on or before **4:30 p.m. on September 19, 2012** at the location/address noted below.

Michael Fuller
Department of Public Health
410 Capitol Avenue, MS#11CCS
P.O. Box 340308
Hartford, CT 06134-0308

E-mail Communications

All e-mail communications are to be sent to Michael Fuller at michael.fuller@ct.gov

Questions and Answers

Applicants can e-mail any questions they may have regarding the preparation of the application to Michael Fuller at michael.fuller@ct.gov. Questions regarding the preparation of proposals in response to this RFP must be received by DPH via e-mail no later than **4:30 p.m. on August 24, 2012**. All written questions and responses will be sent via e-mail to all applicants who request the RFP no later than **4:30 on August 29, 2012**.

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I. Statement of Purpose

The DPH addresses the serious public health concerns of breast and cervical cancer, heart disease, and colorectal cancer through the funding and establishment of contracts with health care providers throughout the State of Connecticut. To meet the health care needs of underserved populations, contracted providers will offer high quality, timely, integrated early detection screening and diagnostic follow-up services, and referrals for medical evaluation and treatment to uninsured or underinsured women and men who are at or below the 250% FPL and meet age eligibility requirements.

II. Background

Early detection, coupled with a timely assessment and quick and effective response, is viewed as one of the best and most cost-efficient way of dealing with a health problem. This holds true for the early detection, intervention, and treatment of chronic diseases like cancer of the breast, cervix, colon, and rectum and for the identification and reduction of modifiable risk factors contributing to cardiovascular disease.

Early detection, risk reduction, and intervention can save lives, reduce the extent of needed treatments, and improve quality of life. The provision of appropriate and timely screening services for populations burdened with the highest incidence of chronic disease is essential in reducing the burden of chronic disease in Connecticut.

Cancer

Aside from non-melanoma skin cancer, breast cancer is the most common cancer diagnosed among women in the United States. It is also one of the leading causes of cancer death among women of all races and Hispanic origin populations. Getting a regular screening test is the best way for women to lower their risk of dying from breast cancer. In Connecticut, an average of 2,860 women are diagnosed with breast cancer and an average of 524 women die from breast cancer each year. When breast cancer is detected early (at the localized stage) the national 5-year survival rate is 98%. Over 30% of women diagnosed with breast cancer are diagnosed after breast cancer has spread beyond this stage.

The incidence of cervical cancer is much lower than that of the breast. In Connecticut, an average of 121 women are diagnosed with cervical cancer and an average of 35 women die from cervical cancer each year. Although the diagnosis of cervical cancer is much lower, almost all of these deaths are considered to be preventable with early detection and treatment.

Of cancers affecting both women and men, colorectal cancer (cancer of the colon and rectum) is the second leading cancer killer in the United States. In Connecticut, an average of 1,926 adults are diagnosed with colorectal cancer and an average of 625 die from the disease. Connecticut death rates for colorectal cancer are higher for men than women but have been declining over time for both genders. This trend may reflect advances in screening and detection and improved treatments. The CIHSP, with support from the CDC, continues to help prevent colorectal cancer by providing a limited number of publically funded colonoscopies, building community partnerships, encouraging screening, supporting education and training, and conducting surveillance.

Heart Disease

Heart disease is the leading cause of death for people of most ethnicities in the United States including African Americans, Hispanics, and Whites. For American Indians or Alaska Natives and Asians or Pacific Islanders, heart disease is the second leading cause of death behind cancer. Risk factors for heart disease include hypertension, diabetes, obesity/inactivity, and smoking.

In the United States during 2008, over 616,000 people died of heart disease with coronary heart disease being the most common (65%). Every year about 785,000 Americans have a first coronary attack. Each year another 470,000 Americans who have already had one or more attacks have another. In 2010, coronary heart disease alone was projected to cost the United States \$108.9 billion for the costs of health care services, medications, and lost productivity.

Hypertension (High Blood Pressure)

In Connecticut, 25% of adults are estimated to suffer from hypertension. The rate is highest for black, non-Hispanic adults (36%), adults with less than a high school education (35%), and adults making less than \$25,000 annually (34%).

For people with heart disease, studies have shown that lowering cholesterol and blood pressure levels can reduce the risk of dying from heart disease, having a non-fatal heart attack, and needing heart bypass surgery or angioplasty. For people without heart disease, lowering cholesterol and blood pressure levels can reduce the risk for developing heart disease.

Diabetes

Diabetes is the eighth leading cause of death in Connecticut. The prevalence of diabetes in Connecticut has increased significantly since the late 1990s. Approximately 186,000 of Connecticut adults have diagnosed diabetes and an additional 93,000 adults are estimated to have undiagnosed diabetes. Older adults, low-income adults, and racial and ethnic minorities have the highest rates of diagnosed diabetes. Thirteen percent (13%) of Connecticut adults with household incomes under \$15,000 report having diabetes compared with 4% of Connecticut adults with household incomes over \$50,000. Of particular concern is that nearly 50% of Connecticut adults with diabetes reported they had never taken a course on how to manage the disease.

Access to health care is crucial to the prevention, treatment, and management of diabetes. Targeted public health interventions that address risk factors for the development of diabetes, timely diagnosis of the disease, as well as appropriate preventive care for those diagnosed with diabetes are warranted for the Black, Hispanic, and low-income populations in Connecticut. Approximately 30% of Hispanic, 21% of Black, and 6% of White adults in Connecticut do not have health insurance.

In 2008, approximately \$128 million (\$77 million in 2002) was billed for hospitalizations in Connecticut due to diabetes as a principal diagnosis while almost \$46 million (\$39 million in 2002) was billed for diabetes-related hospitalizations with a lower extremity amputation. Diabetes also incurs enormous indirect costs due to illness, lost productivity, and premature death. According to the Centers for Disease Control and Prevention, diabetes cost Connecticut an estimated \$1.7 billion in direct and indirect costs in 2003.

Obesity / Inactivity

High calorie diets, along with less physical activity, have contributed to the increasing prevalence of obesity across the nation. Obesity is the chief modifiable risk factor for diabetes. In Connecticut, an estimated 21% of adults are considered obese and another 37% of adults are overweight. An estimated 82% of adults with diabetes in Connecticut are overweight or obese. Males, Black adults, older adults, and low-income adults are more likely to be obese.

Smoking

Tobacco use is the leading cause of preventable death in the US. The single most important thing for health is to be tobacco-free. Smoking is the number one cause of heart disease and heart disease is the leading cause of death for most ethnicities in the US. Smoking is also responsible for more than 90% of all lung cancer deaths.

There are 444,000 (16.7%) adult tobacco users in Connecticut. Cigarette smoking among Connecticut adults varies by age, race and ethnicity, and socioeconomic measures such as level of education and income. The prevalence of smoking is highest among adults in the 18-24 year-old age group (29.1%), among adults with salaries of less than \$40,000 (28.5%), in the Hispanic population (26%), and among those who have less than some college education (23.5%).

In Connecticut, 75% of adult smokers smoke daily and 44% of them smoke a pack of cigarettes or more per day. Nearly three-quarters (72%) of them want to quit smoking for good and 57% tried to quit during the past year. Adult smokers (13.7%) are less likely than non-smokers (24.8%) to report that their general health is excellent and they are twice as likely (33.5%) as non-smokers (15.9%) to have been diagnosed with a chronic lung disease such as emphysema. In Connecticut, the majority of adults (60%) have smoked at least one cigarette per day for 30 days in a row at some point during their lives and it is estimated that 4,700 die each year as a direct result of their own smoking. It is also estimated that 186,000 children are exposed to secondhand smoke in their homes. Another 80,000 middle school and high school students have tried cigarette smoking and each year 4,300 adolescents become daily smokers.

III. Proposal Content Requirements

Proposals must be submitted on the DPH Application Forms included in Attachment C. All requirements of this RFP must be met. Content requirements not addressed by the DPH Application Forms must be submitted in narrative form with numbered pages.

A. Applicant Information

The application must contain the official name, address, e-mail address, and phone number of the applicant, the principal contact person for the application, and the name and signature of the person (or persons) authorized to execute the contract.

B. Contractor Information

You must provide the name, title, address, e-mail address, telephone and FAX numbers of staff persons responsible for the completion and submission of contract and legal documents, forms, program progress reports, and financial expenditure reports.

Also indicate whether or not the agency is incorporated, the type of agency applying for funding, the fiscal year for the applicant's agency, the agency's federal employer ID number and/or town code number, the applicant's Medicaid provider status and Medicaid number, if any, and if the applicant agency is registered as a Connecticut Minority Business Enterprise and/or Women Business Enterprise.

C. Provision of Services

The CIHSP is grounded in Public Law regulated by the Federal Government and administered and directed by the DPH according to DPH and the Centers for Disease Control and Prevention mandates and guidelines. These laws, their amendments, and guidelines specify necessary activities required for compliance by all funded grantees and their representatives in the implementation of the CIHSP.

Disease Burden and Need

Provide a brief description of:

The number of uninsured and low income women (250% of the Federal poverty level) living in the service area by age (21-64 years) and by race/ethnicity.

- The extent of the breast and cervical cancer burden and the need among women who are eligible for mammography and cervical screening services, identifying areas within the service area that have the greatest need; and,
- The extent of the heart disease and stroke burden and the need among women who, eligible for breast and cervical screening services, are also eligible for cardiovascular risk reduction screening, identifying areas within the service area that have the greatest need.

The number of women and men living in the service area by age (50-64 years) and by race/ethnicity.

- The extent of colorectal cancer burden and the need among women and men who are eligible for colorectal cancer screening services within the service area that have the greatest need.

Cancer Community Advisory Council (CCAC)

A Cancer Community Advisory Council (CCAC) is an effective means of establishing community wide partnerships that will enhance the coordinated approach required to provide and sustain services to CIHSP participants and to support CIHSP participants and their families in adopting and sustaining healthy lifestyles.

Each funded CIHSP will be required to develop, support, and work with a standing CCAC. Therefore, applicants must identify the potential membership of their advisory council and submit a membership list as part of the application. The membership list needs to contain the names of the members, credentials, agency affiliations, and agency addresses along with letters of support from each member.

The funded applicant must mobilize and support a standing CCAC with an identified chairperson (not the lead agency) and a minimum of seven additional members. Submit the membership list to michael.fuller@ct.gov no later than 90 days from the date of the CIHSP award. The list should include the chairperson and a minimum of seven members and their contact information.

The purpose of the CCAC is to complement the knowledge and skills of the CIHSP through representation of key stakeholders in the community service area who can provide an external perspective on the program, advocate for the program, increase its visibility, provide guidance, communicate opinions, share expertise, support the coordination of services, and contribute to improving the health of the community. The CCAC serves in an advisory capacity. It does not have formal authority to govern the CIHSP nor does it have fiduciary responsibility. CIHSP advice and recommendations are non-binding.

CCAC membership can include partner organizations, health professionals, and other community members who can enhance and contribute to the mission of the CIHSP. Health departments and federally qualified health centers should be invited to participate on the CCAC. Council membership should reflect the diversity of the community and include representatives from the community's cultural and ethnic minority organizations. Representatives from townships who can influence activities and changes in town policies and support towards increased physical activities and healthy eating habits should also be considered.

Performance of the grantee will be measured by evidence of:

- The extent to which the CCAC is supported by the CIHSP;
- The extent to which the CCAC provides recommendations that are relevant to the purpose and direction of the CIHSP; and,
- The extent to which the CCAC is comprised of population subgroups that experience health disparities, representatives from chronic disease and risk factor programs, and members of non-health sectors in the community.

Recruitment, Screening and Rescreening of Priority Populations

Applicants must identify in the application how they will carry out the recruitment and screening and rescreening activities.

Recruitment: Providers must provide public education, targeted outreach, and inreach (eligible populations within provider practices) to recruit and enroll participants into the CIHSP who meet the eligibility requirements. Recruitment activities need to include community level outreach and education through the use of community events and multiple media channels with an emphasis on electronic media channels including social networking sites.

An annual public education, outreach plan, and inreach plan that include the use of multiple electronic media channels developed in collaboration with the Cancer Community Advisory Council must be submitted to DPH with the first Tri-Annual Program Report. The plan should include details on the provider's outreach efforts to reach men for colorectal cancer screening.

Screening and Rescreening: Once clients are enrolled in the CIHSP, grantees are responsible for the provision and tracking of screening and rescreening services targeted to priority populations according to eligibility and established protocols and time frames. Screening and rescreening services consist of the same protocols and are to include a combination of tests for breast, cervical, colon, and rectal cancer, and identification of modifiable risk factors of heart disease.

Screening tests for cholesterol and glucose can be performed by venipuncture or by use of the Cholestech LDX System which uses a fingerstick method. Applicants are urged to consider the fingerstick method since the fingerstick can be performed during the office visit and the results shared with the participant along with risk reduction counseling at the office visit. The use of this method increases the number of women who participate in the heart disease risk reduction screening program.

Applicants who select this method must identify the protocol they will use to implement the Cholestech LDX System. The protocol must include the name of the laboratory and laboratory director who will oversee the use of the Cholestech LDX System. Funded applicants will receive training concerning the use of the Cholestech LDX System.

The use of the Cholestech LDX System takes place under the supervision of a CLIA-Certified Laboratory according to the requirements of 42 CFR Part 493, Laboratory Requirements Clinical and Laboratory Improvements Amendments (CLIA), Public Health Service Act, Subpart 2, Chapter 3535 Clinical Laboratories, located at <http://wwwn.cdc.gov/clia/regs/toc.aspx> and may be updated and revised periodically.

Performance of the grantee will be measured by evidence of:

- The implementation of the annual public education, outreach, and inreach plans;
- Meeting contracted screening objectives on a tri-annual basis;
- The extent to which rarely or never screened women are identified and screened for breast and cervical cancer;
- The extent to which participants are rescreened according to nationally recommended guidelines; and,
- The appropriate laboratory oversight of the use of the Cholestech LDX System and completion of staff training.

Evenings and Weekend Services

Funded applicants **must** provide CIHSP services on at least one evening per week or one weekend per week to permit access for potential participants who cannot schedule appointments for screening services during regular business hours. Applicants must identify in the application how and when they will meet this requirement.

Performance of the grantee will be measured by evidence of:

- CIHSP services being offered to participants at least one evening per week or one weekend per week.

Risk Reduction Counseling, Community Resources Guide, Medication Resources Guide, and Lifestyle Counseling

Risk Reduction Counseling: All eligible CIHSP participants who are screened for modifiable risk factors for heart disease must receive risk reduction counseling that addresses increased physical activity and healthy eating habits verbally and in writing once test results are available. Risk reduction counseling can be delivered by provider personnel who are trained/approved to provide risk reduction counseling by DPH. Risk reduction counseling can take place at the office visit if Cholestech LDX System fingerstick test results are available or by telephone after the office visit if a venipuncture was performed. The fingerstick method facilitates the number of women who will actually receive risk reduction counseling since it takes place during the office visit. Risk reduction counseling requires 15-30 minutes of time based upon screening results. The time it takes to provide risk reduction counseling needs to be built into the time it takes to provide CIHSP services. A standardized risk reduction form is provided for use during the counseling session and must be given to the participant to take home. A red folder containing health education information provided by DPH must also be given to each participant receiving risk reduction counseling.

Community Resources Guide: Each person who receives risk reduction counseling must also be given a list of community resources that support physical activity and healthy eating habits.

Medication Resources Guide: Participants who are screened for heart disease risk factors and have abnormal test results must also be given a list of free or discounted medications resources.

Lifestyle Intervention Counseling: CIHSP participants who have been screened for heart disease risk and are found to have abnormal test results may receive lifestyle counseling from a state level DPH registered dietitian if they wish to do so. One to three lifestyle interventions are provided to the participant based upon the degree of heart disease risk.

Performance of the grantee will be measured by evidence of:

- The provision of risk reduction counseling to all eligible CIHSP participants verbally and in writing;
- The provision of a copy of the Community Resources Guide to DPH for review and approval as part of the first Tri-Annual Program Report;
- The provision of a copy of the Medication Resources Guide to DPH for review and approval as part of the first Tri-Annual Program Report; and,
- The provision of lifestyle intervention counseling.

Provision of Case Management, Patient Navigation, Diagnostic Follow-up, and Referrals

Applicants must identify in the application the protocols that will be used to carry out the provision of case management, patient navigation, diagnostic follow-up, and referral services.

Case Management: CDC requires that all participants with an abnormal screening result be assessed for needing case management services and provided with such services accordingly based upon the assessment. Case management services in the CIHSP are designed to ensure that all women with abnormal breast and/or cervical cancer screening results are able to comply with the recommended clinical follow-up.

Case management services are to be provided by a Connecticut registered nurse (RN), nurse practitioner (APRN), or licensed clinical social worker (LCSW) to ensure that participants identified with abnormal screening results are able to comply with the recommended clinical follow-up and/or receive support if needed. After a needs assessment is completed and case management services are determined necessary, the provider must document the completed process using the DPH needs assessment forms and patient care plans.

Performance of the grantee will be measured by evidence of:

- Completion of assessment for need of case management;
- Adherence to the time interval between receipt of abnormal results and patient notification;
- Adherence to the time interval between patient notification and date of assessment;
- Documentation of the delivery of case management services if needed;
- Documentation of referral to treatment and/or to free/reduced cost services; and,
- Compliance with performance indicators.

Patient Navigation: A patient navigator is defined as a trained, culturally sensitive health care worker who provides support and guidance throughout the cancer care continuum. Patient navigator duties include helping patients to navigate through the maze of doctors' offices, clinics, hospitals, outpatient centers, insurance and payment systems, patient-support organizations, and other components of the health care system.

Patient navigation services in the CIHSP are designed to achieve timely delivery of colorectal cancer screening services and patient satisfaction with their respective encounters within the cancer care system. Patient navigators are required to guide participants through the appropriate diagnostic follow-up and treatment referrals for patients identified with abnormal findings and/or are diagnosed with colorectal cancer. Patient navigation services may be delivered by a licensed social worker, licensed nurse navigator, or other DPH approved trained staff.

Performance of the grantee will be measured by evidence of:

- Documentation of adherence to eligibility guidelines for participation in the CIHSP.

Diagnostic Follow-up and Referrals: All eligible participants screened for breast and/or cervical cancer who have abnormal test results must be referred for follow-up diagnostic services, and if needed, treatment of a cancer diagnosis.

All eligible participants screened for heart disease risk reduction services and identified with abnormal test results must be referred to an existing medical care system for evaluation and treatment. Participants with results that are very high (alert values) must be referred to the existing medical care system within seven days. Follow-up on participant arrival and treatment at the medical care facility must be confirmed and documented in the program data base for all participants with alert values.

All eligible participants screened for colon cancer and have abnormal results must be referred into a medical home for primary care follow-up.

Applicants must submit an integrated protocol for ensuring that CIHSP participants will receive diagnostic follow-up and referrals to treatment resources. For those participants who are not eligible for treatment services through Medicaid, applicants must negotiate treatment services from alternative resources.

The project director along with all pertinent staff will be responsible for making and tracking appropriate diagnostic follow-up and referrals for patients based on established guidelines and protocols.

Performance of the grantee will be measured by evidence of:

- Documentation of a final diagnosis of breast cancer or not breast cancer within 90 days of the initial abnormal finding;
- Documentation of a final diagnosis of cervical cancer or not cervical cancer within 60 days of the initial abnormal finding; and,
- Documentation of referral to treatment for participants with alert values for medical evaluation within seven days of the office visit with confirmation of date of arrival and treatment.

Treatment Policies

The applicant must identify in the application how treatment policies and procedures will be implemented as described below.

CIHSP funds cannot be used for treatment services for any screening participant found to have an abnormality. The project director along with all pertinent staff will be responsible for making appropriate referrals for patients based on established guidelines and protocols for treatment referrals.

Women with abnormal breast or cervical screening results must be assessed for their need of case management services and provided such services accordingly and in a timely fashion. Those participants who have abnormal breast/cervical screening results should be given priority for diagnostic services. For diagnostic procedures not covered under this program, providers must develop and implement a referral protocol to cover needed procedures.

Women screened for breast/cervical cancer and found to have a precancerous condition or cancer of the breast or cervix and are eligible are provided Medicaid coverage or treatment through legislation enacted by the Connecticut Breast and Cervical Cancer Prevention and Treatment Act (CBCCPA) of 2001.

Women who have received breast/cervical cancer screening services and are screened for heart disease and found to have abnormal test results for blood pressure, cholesterol, and glucose are referred to the existing medical care systems, such as federally qualified health centers, for medical evaluation and treatment and are provided with a list of free or discounted medication resources.

Participants screened for colorectal cancer and found to have cancer or some other bowel disease should be referred for follow-up and treatment. Currently, there is not a treatment act for the colorectal cancer screening portion of the CIHSP. The CIHSP does not cover treatment costs associated with colorectal cancer or other bowel diseases. Applicants are required to assist participants not eligible for treatment services through Medicaid to negotiate treatment services from alternative resources.

Data Management Policies and Procedures

Applicants must identify in the application how data management policies and procedures will be implemented.

Minimum Data Elements: A standardized set of clinical and demographic data elements called Minimum Data Elements (MDEs) are required to be collected and reported for each participant screened by the CIHSP. Grantees must comply with the collection and electronic reporting of all required minimum data elements. Screening, diagnostic, and intervention data must also comply with data quality standards set by the CDC. DPH will provide standardized data collection forms and a secure, web-based, electronic data management system (Med-IT) to assist grantees in these efforts.

CDC Performance Criteria: The federal government funds programs based upon specific performance criteria which can be found in Attachment A. All providers will be held accountable for compliance with these criteria.

Performance of the grantee will be measured by evidence of:

- Timely, accurate, and complete data entry into Med-IT;
- Compliance with program protocols as reflected in data documentation; and,
- Compliance with CDC's required performance measures.

CDC Performance Criteria: The federal government funds programs based upon specific performance criteria which can be found in Attachment A. All providers will be held accountable for compliance with these criteria.

Quality Assurance and Quality Improvement

Applicants must submit a plan to ensure the quality of services delivered through the CIHSP to monitor performance and identify opportunities for improvement and to plan effective strategies for improving services.

Performance of the grantee will be measured by evidence of:

- Documentation of plan objectives;
- Documentation of plan implementation and tracking;
- Documentation of analysis of the plan outcomes; and,
- Documentation of resulting modifications to the plan.

D. Fiscal Management

The applicant must identify in the application how fiscal management will be implemented.

As the payer of last resort, providers are responsible for sound fiscal management to maximize the utilization of program funds. Fiscal management includes the development, implementation, and oversight of an appropriate budget. Fiscal management also includes routine systematic oversight of expenditures and reporting procedures.

Expenses must not exceed the allocated funding amounts awarded under the contract. Invoices submitted for reimbursement which exceed the designated funding award will be returned unpaid and must not result in bills being sent to program participants.

Budget

The applicant must identify in the application a budget that accurately reflects programmatic costs and related justifications.

The proposal must contain an itemized budget with justification for each line item on the budget forms which can be found in Attachment C. All costs (travel, printing, supplies, etc.) must be included in the requested contract amount. Competitiveness of the budget will be considered as part of the proposal review process.

The State of Connecticut is exempt from the payment of excise, transportation, and sales taxes imposed by the Federal and/or State Government. Such taxes must not be included in the requested contract amount.

The maximum amount of the bid may not be increased after the proposal is submitted. All cost estimates will be considered as "not to exceed" quotations against which time and expenses will be charged.

The proposed budget is subject to change during the contract award negotiations.

All information required of the contractor must be applied to the subcontractor as well.

Copies of state set aside certifications for small and/or minority businesses must also be provided.

Payments will be negotiated based on time frames and deliverables described in section V of this RFP.

Clinical Reimbursement Policies

The applicant must identify in the application how clinical reimbursement policies will be implemented.

All participants must be verified as eligible and all services deemed appropriate before services are provided. Program participants must not be billed for any portions of any services provided under the CIHSP. In the event that services provided cannot be reimbursed with program funds, the provider must absorb the costs.

The CIHSP is a payer of last resort. CIHSP funds can be used only to reimburse for services authorized by the CIHSP. Clinical services are reimbursed at the maximum Connecticut adjusted Medicare Reimbursement rate. Clinical services and allowable reimbursement rates are published annually by DPH. The 2012-2013 Connecticut Allowable Procedures and Relevant CPT Codes can be found in Attachment B.

E. Work Plan

A comprehensive and realistic work plan which contains measurable objectives describing key tasks to be performed, deliverables, and timelines, including a project start date, must be provided on the Application Forms. The work plan must be consistent with the RFP and the project's goals and objectives. The project start date will be considered as part of the review criteria for this RFP.

F. Staffing, Staff Responsibilities, and Professional Education

Proper staffing, adequate staff time, and staff education are essential to ensure that providers meet the goals and objectives of the CIHSP and maintain a quality program. It is important that each applicant identify qualified and competent staff who will be integral to meeting program outcomes.

The following staffing requirement for the CIHSP is expected of all grantees. Any deviation from these requirements will be assessed and approved or disapproved by the DPH on an individual grantee basis.

Project Director

In-kind

- Active leadership which includes oversight, supervision, and direction for CIHSP staff and services
- Fiscal oversight and management
- Lead person to mobilize and support Cancer Community Advisory Council
- Review/approval of deliverables
- Participation in mandated DPH provider meetings
- Primarily responsible for communication with DPH

Program Coordinator

1.0 Full-time employee (FTE)

- Day-to-day operations and coordination
- Support Cancer Community Advisory Council
- Participation in mandated provider meetings

Case Manager

Minimum 20 hours per week

- Timely assessment and case management of participants with abnormal findings
- Participation in mandated DPH provider meetings

Patient Navigator

Minimum 10 hours per week

- Facilitate timely delivery of colorectal cancer screening services
- Participation in mandated DPH provider meetings

Outreach/Marketing Assistant

Minimum 10 hours per week

- Recruitment and marketing of program services
- Develop/implement electronic media plan
- Target rarely or never screened participants
- Support Cancer Community Advisory Council
- Participation in mandated DPH provider meetings

Data Entry Specialist

Minimum 10 hours per week

- Accurate and timely organization and documentation of program data
- Participation in mandated DPH provider meetings

Performance of the grantee will be measured by:

- E-mail notification of DPH within five days of program staffing changes; and,
- Maintaining a full complement of staff

G. Contract Compliance

The proposal must include a completed Notification to Bidders form (return one and keep one for your records) and a Workforce Analysis Questionnaire. In addition, proposals must include a signed statement of adherence to Assurances.

IV. Application Procedures

Applicants must complete their proposal using the following procedures:

1. An original and five bound copies of the completed proposal must be addressed to:

Michael Fuller
Department of Public Health
410 Capitol Avenue, MS#11CCS
P.O. Box 340308
Hartford, CT 06134-0308

Proposals must be received at DPH in person or by US Mail postmarked on or before **4:30 p.m. on September 19, 2012.**

2. The proposal must be completed on the Application Forms and meet all requirements of this RFP.
3. The original proposal must be signed and dated by an authorized official of the applicant organization.
4. Supplemental information will not be considered after the deadline submission of proposals unless specifically requested by DPH.
5. Notification of the outcome of proposal review will be mailed to all applicants. A contract will be mailed to the successful applicant on or about **November 15, 2012.**
6. The program start date is **July 1, 2013.** Screening services must begin no later than **October 1, 2013.**

V. Deliverables/Payment Schedules

Providers are required to submit, as part of the contractual obligation, three CIHSP Program Reports annually, at four-month intervals, and if needed, Final Year-end Reports. The CIHSP Program Report consists of a cover letter under the signature of the project director, the Financial Expenditure Report, the Contract Balance Report (Med-IT), and the Program Narrative Report. Program Reports will be due on the following dates:

Reporting Periods	Report Due Dates
July 1, 2013-October 31, 2013-17	December 1, 2013-17
November 1, 2013-February 28, 2014-18	April 1, 2014-18
March 1, 2014-June 30, 2014-18	August 1, 2014-18
Final Reports	September 1, 2014-18

Payments will be based on provider performance. Provider performance and compliance with contractual obligations, including CIHSP screening objectives, will be measured using the information provided in the program reports, from data residing on the web-based Med-IT system, and during site visits. Development of program reports must be included as objectives in the project Work Plan described in Section III of this RFP. Work Plan forms are included in Attachment C.

VI. Supervision

Carol Anderson, Coordinator of the Connecticut Breast and Cervical Cancer Early Detection Program in the Public Health Initiatives Branch at DPH will provide oversight of the RFP process.

VII. Review Criteria

A. Review of Minimum Requirements

Proposals submitted in response to this notice will be reviewed to determine completeness of all required elements and compliance with the requirements specified in the RFP. Applications that do not meet these criteria will be disqualified and removed from the review process. In addition, applicants with significant outstanding unresolved issues on current and/or prior contracts with the DPH may be removed from consideration for additional funding. A copy of the Minimum Requirements Checklist can be found on Attachment D.

B. Review of Technical Requirements

Complete proposals will be reviewed and graded for technical merit based on the extent to which they meet the criteria identified below. A copy of the Technical Review Worksheet can be found on Attachment E.

- The applicant has demonstrated successful experience providing similar services;
- The references provided support the applicant's success in providing similar services, including but not limited to case management, screening and diagnostic follow-up, treatment referrals, risk reduction counseling, and tracking systems;
- The profile of staff who will be working on this project is clear and qualified to initiate, manage, and implement the services to be provided;
- The extent to which the CIHSP Cancer Community Advisory Council role and responsibilities are clearly described;
- A thorough Work Plan is presented with measurable objectives that addresses key program components and specific timelines;
- A cost effective budget is presented which follows eligibility guidelines;
- The budget identifies the type and amount of in-kind resources;
- The budget identifies the number of participants to be screened;
- The budget identifies the cost per participant screened;
- The applicant provides evidence that it will utilize small and minority businesses, whenever feasible and appropriate, in the purchase of supplies and services funded through this contract; and,
- The budget is fiscally competitive.

C. Review Process

A panel of appropriate staff and outside experts will review proposals which meet the minimum requirements. This panel will make recommendations concerning the selection of a proposal for funding. Recommendations to the DPH Commissioner will be submitted in rank order based on team scores for each proposal. The final selection is at the discretion of the DPH Commissioner.

Following the final selection, a Personal Service or Human Services Agreement will be developed between the applicant and DPH that details services to be provided, budget, and reporting requirements. No financial obligation by the State can be incurred until a contract is fully executed.

VIII. Regulatory Compliance

Moreover, in accordance with Section 4a-60 of the Connecticut General Statutes, as amended by Public Act 07-142, Section 9, the awardee shall agree and warrant that in the performance of this award, he/she will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, religious creed, age, marital status (including civil unions, per Public Act 07-245, Section 2), national origin, ancestry, sex, mental retardation, mental or physical disability, but not limited to, blindness unless it is shown by the awardee that such disability prevents performance of the work involved, in any manner prohibited by the laws of the United States or the State of Connecticut.

Also, in accordance with Section 4a-60a of the Connecticut General Statutes, as amended by Public Act 07-142, Section 10, the awardee shall agree and warrant that in performance of this award, he/she will not discriminate or permit discrimination against any person or group of persons on the grounds of sexual orientation, in any manner prohibited by the laws of the United States or the State of Connecticut, and that employees are treated when employed without regard to their sexual orientation.

Also, in accordance with Section 46a-81c(1) of the Connecticut General Statutes, as amended by Public Act 07-245, Section 3, the awardee shall agree and warrant that in performance of this award, he/she by him/herself or her/his agent, except in the case of a bona fide occupational qualification or need, will not refuse to hire or employ or bar or discharge from employment any individual or discriminate against such person in compensation or in terms, conditions, or privileges of employment, because of the person's sexual orientation or civil union status.

The awardee shall further agree to provide the Commission on Human Rights and Opportunities with such information requested by the Commission concerning the employment practices and procedures of the awardee as they relate to the provisions of Section 4a-60 and Regulations of Connecticut State Agencies, Sections 46a-68J-2 to 46a-68K-8.

Further, in accordance with the Contract Compliance Regulations of Connecticut State Agencies, the applicant will be required to complete the Notification to Bidders form and the Workforce Analysis Questionnaire as part of the application process included in Attachment A.

IX. Affirmative Action Notice

DPH strongly supports the concept and implementation of affirmative action to overcome the present effects of past discrimination. DPH urges its bidders, suppliers, contractors, and awardees to implement affirmative action plans and programs of their own, and hereby notifies all DPH bidders, suppliers, contractors and awardees that DPH will not knowingly do business with, or make awards to any individual or organization excluded from participation in any federal or state contract program, or found to be in violation of any state or federal anti-discrimination law.

X. Rights Reserved to the State

The State of Connecticut reserves the right to reject any and all proposals, in whole or in part waive technical defects, irregularities, and omissions if, in its judgment, the best interest of the State will be served.

XI. Attachments

The intent of this appendix is to review how the Data Quality Indicator Guide (DQIG) can be used to monitor adherence to several of CDC's clinical management policies.

The following policies are excerpts from the NBCCEDP Program Guidance Manual, Policy and Procedures Chapter. These were developed by the CDC's Division of Cancer Prevention and Control (DCPC) specifically for the NBCCEDP.

The exact algorithms for the calculation of those DQIG items which are Core Performance Indicators (CPI) can be located on the www.nbccedp.org Web site. A document under the Files tab: [Meetings | Web Conferences | 20051102-MDE- Algorithms](#) outlines how the numerator and denominator are calculated using MDE version 5.0 data item references. Updated algorithms with version 6.0 data item references will be posted on the site as available.

Policy No.	CDC Clinical Management Policy	DQIG Reference
PC.1	Mammography for Women 50 Years of Age or Older	<u>DQIG Item 19.e (CPI)</u> Percentage of mammograms provided to women 50+ years of age should be $\geq 75\%$.
PC.2	Mammography for Women Under 50 Years of Age	<u>DQIG Item 19.e (CPI)</u> Percentage of mammograms provided to women 50+ years of age should be $\geq 75\%$.
PC.6	Managing Women With Abnormal Breast Cancer Screening Results	<u>DQIG Item 20.a (CPI)</u> Percentage of women with suspicious or abnormal breast cancer screening results who have a diagnostic procedure and a final diagnosis recorded should be $\geq 90\%$.
PC.7	Increasing Screening for NBCCEDP-Eligible Women Never or Rarely Screened	<u>DQIG Item 6.a (CPI)</u> $\geq 20\%$ of women whose first NBCCEDP funded Pap test should be in the category of Never/Rarely screened (i.e. no prior Pap test or Previous Pap test was ≥ 5 years prior to the first NBCCEDP funded Pap test date)
PC.13	Managing Women With Abnormal Cervical Cancer Screening Results	<u>DQIG Item 11.a (CPI)</u> Percentage of women with abnormal cervical cancer screening results who have a diagnostic procedure and a final diagnosis recorded should be $\geq 90\%$.

CDC Based Program Policies and the Data Quality Indicator Guide

Policy No.	CDC Clinical Management Policy	DQIG Reference
PC.15	Adequacy of Follow-up for Women With Abnormal Screening Results	<p><u>DQIG Item 7.a</u> Percentage of women with diagnostic work-up planned based on suspicious cervical cancer screening results who have a diagnostic procedure and a final diagnosis recorded should be $\geq 90\%$.</p> <p><u>DQIG Item 11.a (CPI)</u> Percentage of women with abnormal cervical cancer screening results who have a diagnostic procedure and a final diagnosis recorded should be $\geq 90\%$.</p> <p><u>DQIG Item 17 (CPI)</u> Percentage of women with a final diagnosis of HSIL, CIN II, CIN III/CIS or invasive cervical carcinoma who have started treatment should be $\geq 90\%$.</p> <p><u>DQIG Item 20.a (CPI)</u> Percentage of women with suspicious or abnormal breast cancer screening results who have a diagnostic procedure and a final diagnosis recorded should be $\geq 90\%$.</p> <p><u>DQIG Item 26 (CPI)</u> Percentage of women with a final diagnosis of invasive breast cancer who have started treatment should $\geq 90\%$.</p>

CDC Based Program Policies and the Data Quality Indicator Guide

Policy No.	CDC Clinical Management Policy	DQIG Reference
PC.16	Timeliness of Follow-up for Women With Abnormal Screening Results	<p><u>DQIG Item 16.c</u> The median number of days between Date of Pap test, with abnormal screening result, and Date of Final Diagnosis should be ≤ 60 days.</p> <p><u>DQIG Item 16.d (CPI)</u> The percentage of women with abnormal screening results taking longer than 60 days between screening and final diagnosis should be $\leq 25\%$.</p> <p><u>DQIG Item 18.c</u> The median number of days between Date of Final Diagnosis (of HSIL, CIN II or CIN III/CIS) and Treatment Start Date should be ≤ 90 days.</p> <p><u>DQIG Item 18.d (CPI)</u> The percentage of women with a final diagnosis of HSIL, CIN II, or CIN III/CIS taking longer than 90 days between final diagnosis and treatment should be $\leq 20\%$.</p> <p><u>DQIG item 18.f</u> The median number of days between Date of Final Diagnosis of invasive cervical carcinoma and Treatment Start Date should be ≤ 60 days.</p> <p><u>DQIG Item 18.g (CPI)</u> The percentage of women with a final diagnosis of invasive cervical carcinoma taking longer than 60 days between final diagnosis and treatment should be $\leq 20\%$.</p>

CDC Based Program Policies and the Data Quality Indicator Guide

Policy No.	CDC Clinical Management Policy	DQIG Reference
PC.16	<p>Timeliness of Follow-up for Women With Abnormal Screening Results</p> <p>(continued)</p>	<p><u>DQIG Item 25.c</u> The median number of days between date of abnormal initial screening result and Date of Final Diagnosis should be ≤ 60 days.</p> <p><u>DQIG Item 25.d (CPI)</u> The percentage of women with abnormal initial screening results taking longer than 60 days between screening and final diagnosis should be $\leq 25\%$.</p> <p><u>DQIG Item 27.c</u> The median number of days between Date of Final Diagnosis and Treatment Start Date should be ≤ 60 days.</p> <p><u>DQIG Item 27.d (CPI)</u> The percentage of women with a final diagnosis of invasive breast cancer taking longer than 60 days between final diagnosis and treatment should be $\leq 20\%$.</p>

Connecticut WISEWOMAN Program
CDC Performance Criteria

1. Program provides evidence that it has met or exceeded 95% of its target screening goal (inclusive of baseline screenings and rescreenings). (Calculated using MDEs)
2. Program provides evidence that 35% of WISEWOMAN participants are rescreened 12-18 months following a previous WISEWOMAN screening. Rescreenings that occur after 18 months (delayed rescreenings) will also be considered.¹¹ (Calculated using MDEs)
3. Program provides evidence that a minimum of 75% of WISEWOMAN participants screened with at least one modifiable risk factor attend at least one LSI session. (Calculated using MDEs)
4. Program provides evidence that of the women enrolled in the LSI program, 60% complete all recommended sessions. (Calculated using information from Interim and Annual Progress Reports)
5. Program submits final MDEs by semiannual submission due dates and with a no more than 5% weighted error rate. (Calculated from final MDE submission for each period)
6. Program provides evidence that 100% of women who have an alert screening value are seen by a health care provider within one week of screening (or documentation reflects why this did not happen). (Calculated using MDEs)
7. Program provides evidence that program evaluation is being conducted in a minimum of two program components (i.e., program management, direct services, partnerships) and that the results are being used. (Determined from information provided in Interim and Annual Progress Reports)

Connecticut Colorectal Cancer Early Detection Program
 CDC Performance Criteria

Proposed Indicator Type, Number and Description			CDC Benchmark
Screening Priority Population	1	Percent of new clients screened who are at average risk for CRC	≥ 75%
	2	Percent of average risk new clients screened who are aged 50 years and older	≥ 95%
Completeness of Clinical Follow-up	3	Percent of abnormal test results with diagnostic follow-up completed	≥ 90%
	4	Percent of diagnosed cancers with treatment initiated	≥ 90%
Timeliness of Clinical Follow-up	5	Percent of positive tests (FOBT/FIT, sigmoidoscopy, or DCBE) followed-up with colonoscopy within 90 days (This measure will not apply to all programs)	≥ 80%
	6	Percent of cancers diagnosed with treatment initiated within 60 days	≥ 80%

2012-2013 Connecticut Allowable Procedures and Relevant CPT Codes

CONNECTICUT BREAST & CERVICAL CANCER EARLY DETECTION PROGRAM (CBCCEDP) and
 COLORECTAL CANCER SCREENING PROGRAM (CCRCP) and
 WELL-INTEGRATED SCREENING AND EVALUATION FOR WOMEN ACROSS THE NATION (WISEWOMAN)

CODES		ALLOWABLE CPT CODES & RATES Procedure/Description	REIMBURSEMENT RATES		
MED-IT Codes	CPT Codes		Global Reimbursement	Professional Component	Technical Component
Section 1					
INTEGRATED OFFICE VISITS (Clinical Office Visits Starting a New Screening Cycle) Must include CBCCEDP & CCRCP					
BR204	99204	Initial Breast and Cervical and Colorectal Patient; <i>comprehensive</i> history, exam, decision-making of moderate complexity; 45 minutes	134.79		
BR386	99386	Initial Breast and Cervical and Colorectal Patient; <i>comprehensive</i> preventive medicine evaluation and management; history, examination, counseling/guidance, risk factor reduction, ordering of appropriate immunizations, lab procedures, etc; 40-64 years of age	134.79		
BR214	99214	Established Breast and Cervical and Colorectal Patient; <i>detailed</i> history, exam, decision-making of moderate complexity; 25 minutes	111.65		
BR396	99396	Periodic Breast and Cervical and Colorectal Patient; <i>comprehensive</i> preventive medicine evaluation and management; history, examination, counseling/guidance, risk factor reduction, ordering of appropriate immunizations, lab procedures, etc; 40-64 years of age	111.65		
Section 2					
OFFICE VISITS PROVIDING CBCCEDP SERVICES ONLY (Clinical Office Visits)					
BC201	99201	Initial Patient; history, exam, straightforward decision-making; 10 minutes	45.99		
BC202	99202	Initial Patient; <i>expanded</i> history, exam, straightforward decision-making; 20 minutes	78.05		
BC203	99203	Initial Patient; <i>detailed</i> history, exam, straightforward decision-making of low complexity; 30 minutes	113.18		
BC211	99211	Established Patient; evaluation and management, may not require presence of physician; 5 minutes	21.43		
BC212	99212	Established Patient; history, exam, straightforward decision-making; 10 minutes	45.99		
BC213	99213	Established Patient; <i>expanded</i> history, exam, straightforward decision-making of low complexity; 15 minutes	75.67		
Section 3					
OFFICE VISITS PROVIDING CCRCP SERVICES ONLY (Clinical Office Visits)					
CR201	99201	New Patients, <i>expanded</i> history, exam, straightforward decision-making; 10 minutes	45.99		
CR202	99202	New Patients, <i>expanded</i> history, exam, straightforward decision-making; 20 minutes	78.05		

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2012-2013 Connecticut Allowable Procedures and Relevant CPT Codes

Section 4		WISEWOMAN CLINICAL LABORATORY PROCEDURES		Global Reimbursement
36415	36415	Routine venipuncture		3.00
80048	80048	Basic metabolic profile		11.98
80053	80053	Comprehensive metabolic panel		14.97
80061	80061	Lipid Panel		18.97
82465	82465	Total Cholesterol		6.16
82947	82947	Glucose: quantitative		5.56
83036	83036	Hemoglobin glycosylated (A1C) <i>Used in lieu of other glucose testing for those with previous diagnosis of diabetes</i>		13.75
83718	83718	HDL cholesterol		11.60
Section 5		WISEWOMAN DIAGNOSTIC OFFICE VISIT (WISEWOMAN Return Visits Only)		Global Reimbursement
WW211	99211	Established Patient; evaluation and management, may not require presence of physician; 5 minutes		21.43
WW212	99212	Established Patient; history, exam, straightforward decision-making; 10 minutes		45.99
Section 6		RISK REDUCTION COUNSELING (WISEWOMAN Visits Only)		Global Reimbursement
99401	99401	WISEWOMAN Patient; Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes		38.39
99402	99402	WISEWOMAN Patient; Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes		65.44
Section 7		CBCCEPD-BREAST SCREENING PROCEDURES (Starting New Breast Screening Cycle)		Global Reimbursement
77057	77057	Screening Mammogram, Bilateral (2 view film study of each breast)		88.46
77056	77056	Mammography, Diagnostic Follow-up, Bilateral		122.39
G0202	G0202	Screening Mammogram, Digital, Bilateral		153.45
G0204	G0204	Diagnostic Mammogram, Digital, Bilateral		185.11
Section 8		ADDITIONAL CBCCEPD-BREAST IMAGING PROCEDURES (For Use When Screening Results are Inconclusive)		Global Reimbursement
77055	77055	Mammography, Diagnostic Follow-up, Unilateral		95.64
77056	77056	Mammography, Diagnostic Follow-up, Bilateral		122.39
G0204	G0204	Diagnostic Mammogram, Digital, Bilateral		185.11
G0206	G0206	Diagnostic Mammogram, Digital, Unilateral		146.27
76645	76645	Ultrasound, breast(s), unilateral or bilateral, B-scan and/or real time with image documentation		108.95
				36.28
				44.89
				36.66
				45.65
				52.18
				77.50
				116.79
				139.46
				59.36
				77.50
				139.46
				109.61
				80.90

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2012-2013 Connecticut Allowable Procedures and Relevant CPT Codes

Section 9		AFNORMAL CBCCEDP BREAST SURGICAL CONSULTATIONS (Diagnostic Services for Abnormal Screening Outcome Only)	Global Reimbursement
BX201	99201	Initial Patient; history, exam, straightforward decision-making; 10 minutes	45.99
BX202	99202	Initial Patient; <i>expanded</i> history, exam, straightforward decision-making; 20 minutes	78.05
BX203	99203	Initial Patient; <i>detailed</i> history, exam, straightforward decision-making of low complexity; 30 minutes	113.18
BX204	99204	Initial Patient; <i>comprehensive</i> history, exam, moderate complexity decision-making; 45 minutes	172.20
BX205	99205	Initial Patient; <i>comprehensive</i> history, exam, high complexity decision-making; 60 minutes	213.27
BX211	99211	Established Patient; evaluation and management, may not require presence of physician; 5 minutes	21.43
BX212	99212	Established Patient; history, exam, straightforward decision-making; 10 minutes	45.99
BX213	99213	Established Patient; <i>expanded</i> history, exam, straightforward decision-making of low complexity; 15 minutes	75.67
Section 10		AFNORMAL CBCCEDP BREAST DIAGNOSTIC SERVICES (Diagnostic Services for Abnormal Screening Outcome Only)	Global Reimbursement
10021	10021	Fine needle aspiration without imaging guidance	159.68
10022	10022	Fine needle aspiration with imaging guidance	148.76
19000	19000	Puncture aspiration of cyst of breast	120.04
19001	19001	Puncture aspiration of cyst of breast, each additional cyst, <i>used with 19000</i>	28.08
19100	19100	Breast biopsy, percutaneous, needle core, not using imaging guidance	161.74
19101	19101	Breast biopsy, open, incisional	368.19
19102	19102	Breast biopsy, percutaneous, needle core, using imaging guidance, <i>for placement of localization clip use 19295</i>	230.46
19103	19103	Breast biopsy, percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	599.90
19120	19120	Excision of cyst, fibroadenoma or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; open; one or more lesions	524.87
19125	19125	Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion	581.90
19126	19126	Excision of breast lesion identified by preoperative placement of radiological marker; open; <i>each additional lesion separately identified by a preoperative radiological marker</i>	171.68
19290	19290	Preoperative placement of needle localization wire, breast	173.99
19291	19291	Preoperative placement of needle localization wire, breast; each additional lesion	73.55
19295	19295	Image guided placement, metallic localization clip, percutaneous, during breast biopsy	101.30
77031	77031	Stereotactic localization guidance for breast biopsy or needle placement	157.98
77032	77032	Mammographic guidance for needle placement, breast	58.60
			83.13
			28.71
			74.85
			29.89

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76098	76098	Radiological examination, surgical specimen	20.40	8.26	12.13
76942	76942	Ultrasonic guidance for needle placement, imaging supervision and interpretation	227.59	34.86	192.73
88172	88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)	56.63	35.43	21.20
88173	88173	Cytopathology, evaluation of fine needle aspirate; <i>interpretation and report</i>	150.63	71.29	79.01
88305	88305	Surgical pathology, gross and microscopic examination	115.39	37.90	77.50
88307	88307	Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins	172.71	83.17	172.71
Section 11					
GBCCEDP CERVICAL SCREENING PROCEDURES (Starting New Cervical Screening Cycle)					
Global Reimbursement					
88164	88164	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening under physician supervision	14.97		
88141	88141	Cytopathology (conventional Pap test), cervical or vaginal, any reporting system, <i>requiring interpretation by physician</i>	31.39		
88142	88142	Cytopathology (liquid-based Pap test) cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	28.70		
88143	88143	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening and rescreening under physician supervision	28.70		
87621	87621	Papillomavirus, Human, Amplified Probe <ul style="list-style-type: none"> ▪ Hybrid Capture II from Digene - HPV Test [High Risk Typing, only] ▪ Cervista HPV HR 	49.71		
Section 12					
ABNORMAL CBCCEDP CERVICAL SURGICAL CONSULTATIONS (Diagnostic Services for Abnormal Screening Outcome Only)					
Global Reimbursement					
CX201	99201	Initial Patient; history, exam, straightforward decision-making; 10 minutes	45.99		
CX202	99202	Initial Patient; <i>expanded</i> history, exam, straightforward decision-making; 20 minutes	78.05		
CX203	99203	Initial Patient; <i>detailed</i> history, exam, straightforward decision-making of low complexity; 30 minutes	113.18		
CX204	99204	Initial Patient; <i>comprehensive</i> history, exam, moderate complexity decision-making; 45 minutes	172.20		
CX205	99205	Initial Patient; <i>comprehensive</i> history, exam, high complexity decision-making; 60 minutes	213.27		
CX211	99211	Established Patient; evaluation and management, may not require presence of physician; 5 minutes	21.43		
CX212	99212	Established Patient; history, exam, straightforward decision-making; 10 minutes	45.99		
CX213	99213	Established Patient; <i>expanded</i> history, exam, straightforward decision-making of low complexity; 15 minutes	75.67		

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Section 13		CBCEDP CERVICAL DIAGNOSTIC PROCEDURES (Diagnostic Services for Abnormal Screening Outcome Only)		Global Reimbursement
57452	57452	Colposcopy of the cervix		118.67
57454	57454	Colposcopy of the cervix, with biopsy and endocervical curettage		167.46
57455	57455	Colposcopy of the cervix, with biopsy		156.53
57456	57456	Colposcopy of the cervix, with endocervical curettage		148.16
57460	57460	Endoscopy with loop electrode biopsy(s) of the cervix		317.93
57461	57461	Endoscopy with loop electrode conization of the cervix		357.82
57500	57500	Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)		142.80
57505	57505	Endocervical curettage (not done as part of a dilation and curettage)		112.22
57520	57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser		335.43
57522	57522	Loop electrode excision procedure (LEEP)		288.90
58100	58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)		120.17
58110	58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)		52.28
88174	88174	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision		30.26
88175	88175	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual rescreening, under physician supervision		37.52
88305	88305	Surgical pathology, gross and microscopic examination		115.39
88331	88331	Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen		99.37
88332	88332	Pathology consultation during surgery, first tissue block, with frozen section(s), each additional specimen		43.70
88332				37.90
88332				61.92
88332				30.81
88332				77.50
88332				37.45
88332				12.89
Section 14		CCRCP SCREENING PROCEDURES		Global Reimbursement
G0121	G0121	Screening colonoscopy on average risk individual		438.67
I0121	G0121-53	Interrupted screening colonoscopy on average risk individual		156.47
45378	45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)		438.67
15378	45378-53	Interrupted colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)		156.47
45380	45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple		523.36

Rates Effective July 1, 2012 to June 30, 2013

2012-2013 Connecticut Allowable Procedures and Relevant CPT Codes

45381	45381	Colonoscopy, flexible, proximal to the splenic flexure; with directed submucosal injection(s), any substance.	522.38		
45384	45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cauterization	518.70		
45385	45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	588.24		
Section 15					
CCRCP ANESTHESIOLOGY					
00810	00810	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum	110.05		
Section 16					
CCRCP PATHOLOGY					
88300	88300	Surgical Pathology, gross examination only (surgical specimen)	31.21	4.72	26.49
88302	88302	Surgical pathology, gross and microscopic examination (review level II)	61.67	6.84	54.83
88305	88305	Surgical pathology, gross and microscopic examination, colon, colorectal polyp biopsy (review level IV)	115.39	77.50	84.66
88342	88342	Pathology: Immunocytochemistry; each antibody	114.81	42.98	71.83
Section 17					
CCRCP FACILITY FEE					
00158	00158	Colonoscopy for hospital based outpatient facility	\$400.00		
121SG	G0121-SG	Colorectal Cancer Screening; Average Risk Colonoscopy for ambulatory surgery center	\$400.00		
Section 18					
CCRCP ELECTROCARDIOGRAM					
93000	93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	20.75		
Section 19					
CCRCP BLOOD WORK					
80048	80048	Basic metabolic panel (Calcium, total) This panel must include the following: Calcium (82310) Carbon dioxide (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)	11.98		
85610	85610	Prothrombin time	\$5.56		

Rates Effective July 1, 2012 to June 30, 2013

2012-2013 Connecticut Allowable Procedures and Relevant CPT Codes

PROCEDURES SPECIFICALLY NOT ALLOWED	
Any	Treatment of breast cancer, cervical intraepithelial neoplasia and cervical cancer.
Any	HPV testing for screening purposes
Any	Computer Aided Detection (CAD) in breast cancer screening or diagnostics
Any	Magnetic Resonance Imaging (MRI) in breast cancer screening or diagnostics
Any	Treatment of colorectal cancer or any other cancer diagnosed as a result of participation in the program
Any	Treatment of medical conditions diagnosed as a result of participation in the program or that existed prior to entry into the program
Any	Care and services for complications that result from screening or diagnostic test provided by the program
Any	Evaluation of symptoms for clients who present to CRC screening but are found to have gastrointestinal symptoms
Any	CRC Diagnostic services for clients who had an initial positive screening test performed outside the program
Any	CT Colonography (or virtual colonoscopy) as a primary screening test
Any	Computed Tomography Scans (CTs or CAT Scans) requested for staging or other purposes.

END NOTES

Effective July 1, 2011; Office visits to conduct WISEWOMAN assessments will no longer be reimbursed.

Effective July 1, 2011; WISEWOMAN risk reduction counseling is reimbursed using codes 99401 or 99402.

Effective January 1, 2010; CMS eliminated all consultation codes, which included codes that had been on this list: 99241, 99242, 99243, and 99244. As of that date, consultations should be billed through the standard "new patient" office visit CPT codes: 99201-99205. Effective July 1, 2010 CPT codes: 99201-99205 are to now be coded as BX201-BX205 for breast surgical consultations and CX201-CX205 for cervical surgical consultations in MED-IT. Consultations billed as BX-204 or CX-204 and as BX-205 must meet the criteria for the 99204 and 99205 codes respectively. These codes are not appropriate for NBCCEDP screening visits. The type and duration of office visits should be appropriate to the level of care necessary for accomplishing screening and diagnostic follow-up within the NBCCEDP.

Effective July 1, 2009, the NBCCEDP the digital mammography policy is revised to allow payment for digital screening and diagnostic mammography up to the applicable rates approved by Medicare.

Effective July 2007, reimbursement for liquid-based cytopathology may be made at the appropriate Medicare rate (or less) for these CPT code(s). Programs are expected to provide the following: 1) a budget which incorporates the costs of using LBT on a biennial basis; 2) capability of using CPT codes and MDE codes which reflect which technology was utilized; 3) a method of ensuring that patients are not over screened; and 4) a patient and/or provider reminder system which prevents the loss of patients to follow-up, and ensures that women return biennially for cervical cancer screening.

HPV DNA testing is a reimbursable procedure if used in the follow-up of an ASC-US result from the screening exam, or for surveillance at one year following an LSIL Pap test and no CIN2,3 on colposcopy-directed biopsy. It is not reimbursable as a primary screening test for women of all ages or as an adjunctive screening test to the Pap for women ≥ 30 years of age. Providers should specify the high-risk HPV DNA panel only; reimbursement of screening for low-risk HPV types is not permitted. [Source: 2006 Consensus Guidelines for the Management of Women with Abnormal Cervical Cancer Screening Tests] The CDC will allow for reimbursement of Cervista HPV HR, however, only at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay. CDC funds cannot be used for reimbursement of Cervista HPV 16/18. [Source: Ask Dr Miller Letter, June 2009]

Cytopathology procedures 88143, 88174 and 88175 must be reimbursed at the applicable 88142 Medicare reimbursement rate (or less). [Source: NBCCEDP Blast Email, Dated 9/27/06]

Rates Effective July 1, 2012 to June 30, 2013

2012-2013 Connecticut Allowable Procedures and Relevant CPT Codes

The type and duration of office visits should be appropriate to the level of care necessary for accomplishing screening and diagnostic follow-up within the NBCCEDP, and reimbursement rates should not exceed those published by Medicare. While the use of 993XX-series codes may be necessary in some programs, the 993XX Preventive Medicine Evaluation visits themselves are not appropriate for the NBCCEDP. 9938X codes shall be reimbursed at or below the 99203 rate, and 9939X codes shall be reimbursed at or below the 99213 rate.

[Source: NBCCEDP Blast Email, Dated 2/9/06 and NBCCEDP Blast Email, Dated 12/11/07.]

A LEEP or conization of the cervix, as a diagnostic procedure, may be reimbursed based on ASCCP recommendations and according to their algorithm on the management of women with HSIL. Grantees are strongly encouraged to develop policies to closely monitor these procedures and should pre-authorize this service for reimbursement by having it medical advisory committee or designated clinical representative(s) review these cases in advance, and on an individual basis. [Source: NBCCEDP Blast Email, dated 5/27/04 and the NBCCEDP Policy & Procedures]

CPT codes, descriptions and other data only are copyright 2010 American Medical Association.

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"CPT" is a trademark of the American Medical Association.

Rates Effective July 1, 2012 to June 30, 2013

REQUEST FOR PROPOSAL
RFP # 2013-0901
Connecticut Integrated Health Screening Program (CIHSP)
DEPARTMENT OF PUBLIC HEALTH
COMPREHENSIVE CANCER PROGRAM

A. Applicant Information

Applicant Agency: _____
Legal Name

Address

City/Town State Zip Code

Telephone No. FAX No. E-Mail Address

Contact Person: _____ Title: _____

Telephone No: _____

TOTAL PROGRAM COST: \$ _____

I certify that to the best of my knowledge and belief, the information contained in this application is true and correct. The application has been duly authorized by the governing body of the applicant, the applicant has the legal authority to apply for this funding, the applicant will comply with applicable state and federal laws and regulations, and that I am a duly authorized signatory for the applicant.

Signature of Authorizing Official: Date

Typed Name and Title

The applicant agency is the agency or organization, which is legally and financially responsible and accountable for the use and disposition of any awarded funds. Please provide the following information:

- Full legal name of the organization or corporation as it appears on the corporate seal and as registered with the Secretary of State
• Mailing address
• Main telephone number
• Fax number, if any
• Principal contact person for the application (person responsible for developing application)
• Total program cost

The funding application and all required submittals must include the signature of an officer of the applicant agency who has the legal authority to bind the organization. The signature, typed name and position of the authorized official of the applicant agency must be included as well as the date on which the application is signed.

APPLICATION FORMS

CONTRACTOR INFORMATION

PLEASE LIST THE AGENCY CONTACT PERSONS RESPONSIBLE FOR COMPLETION AND SUBMITTAL OF:

Contract and Legal Documents/Forms:

Name	Title	Tel. No.
Street	Town	Zip Code
Email		Fax No.

Program Progress Reports:

Name	Title	Tel. No.
Street	Town	Zip Code
Email		Fax No.

Financial Expenditure Reporting Forms:

Name	Title	Tel. No.
Street	Town	Zip Code
Email		Fax No.

Incorporated: YES NO

Agency Fiscal Year:

Type of Agency: Public Private Other,
Explain:
 Profit Non-Profit

Federal Employer I.D. Number:

Town Code No:

Medicaid Provider Status: YES NO

Medicaid Number:

Minority Business Enterprise (MBE): YES NO

Women Business Enterprise (MBE): YES NO

APPLICATION FORMS

A. Instructions Budget Summary 1

- I. **Personnel** (lines #1 - #5) each person funded:
- Name of person & title
 - Hourly rate, # hours working per week, and # of weeks. (calculate)
 - Fringe benefit rate. (calculate)

Example:

1. Name & Position: John Smith, Coordinator	
Calculation: \$25.00 hr X 35hrs X 45wks	\$39,375
Fringe Benefit: 26%	\$10,238

- II. Line #11 **Contractual (Subcontracts)** provide the total of all subcontracts and complete Subcontractor Schedule.
- III. Lines #6 - #13 complete categories as appropriate,
- IV. Line # 14: Other Expenses are any other types of expense that do not fit into the categories listed.
For example: Equipment (purchasing a computer at a cost of \$1,500). Please note that the state's definition of equipment is tangible personal property with a normal useful life of at least one year and a value of at least \$2,500 or more.
- V. *****Audit Costs**, the cost of audits made in accordance with OMB Circular A133 (Federal Single Audit) are allowable charges to Federal awards. The cost of State Single Audits (CGS 4-23 to 4-236) is allowable charges to State awards. Audit costs are allowable to the extent that they represent a pro-rata share of the cost of such audit. Audit costs charged to Department of Public Health contracts **must be budgeted, reported and justified as an audit cost line item within the Administrative and General Cost category.**
- VI. Line Item #15 **Administrative and General Costs**, these are defined as those costs that have been incurred for the overall executive and administrative offices of the organization or other expenses of a general nature that do not relate solely to any major cost objective of the overall organization. Examples of A&G costs include salaries of executive directors, administrative & financial personnel, accounting, auditing, and management information systems, proportional office costs such as building occupancy, telephone, equipment, and office supplies. Please review the OPM website on Cost Standards for more information at:
<http://www.ct.gov/opm/cwp/view.asp?a=2981&q=382994>.
- VII. **Administrative and General Costs** must be itemized on the Budget Justification Schedule. Costs that have a separate line item in the Budget Summary may not be duplicated as an Administrative and General Cost. For example, if the Budget Summary includes an amount for telephone costs, this cannot also be included as an Administrative and General Cost.
- VIII. **Other Income**; List any other program income such as in-kind contributions, fees collected, or other funding sources and include brief explanation on Budget Justification.
- IX. **2 Year Contracts**: 2 sets of budget forms have been provided. Please do a full budget for each year of the contract, clearly indicating the year on each form. Assume level funding for the second year.

Note: If space allowed is not sufficient for large or complex subcontract budgets, the Budget Summary format may be copied and used instead.

APPLICATION FORMS

B. Budget Justification Schedule B

- I. Please provide a brief explanation for each line item listed on the Budget Summary. This must include a detailed breakdown of the components that make up the line item and any calculation used to compute the amount.

*****Please note: If Laboratory Services is a line item or subcontractor, please supply a justification as to why a private laboratory is being used as opposed to the Connecticut State Laboratory.**

- II. For contractors who have subcontracts, a brief description of the purpose of each subcontract must be provided. Use additional sheets as necessary.

Example:

Line Item (Description)	Amount	Justification - Breakdown of Costs
Travel	\$730	1,659 miles @ .44 = \$730.00 outreach workers going to meetings and site visits.

C. Subcontractor Schedule A--Detail

- I. All subcontractors used by each program must be included, if it is not known who the subcontractor will be, an estimated amount and whatever budget detail is anticipated should be provided. (Submit the actual detail when it is available). A separate subcontractor schedule must be completed for each program included in the contract. For example: The contract is providing both a Needle Exchange Program and an AIDS Prevention Education Program and Subcontractor "A" is providing services to both programs. There must be a separate budget from Subcontractor "A" for each program.

II. **Detail of Each Subcontractor:**

Choose a category below for each subcontract using the basis by which it is paid:

- A. Budget Basis B. Fee for Service C. Hourly Rate.

Provide the detail for each subcontract referencing the corresponding program of the contract. Detail must be provided for each subcontractor listed in the Summary.

Example A. Budget Basis

Outreach Educator \$20/hr x 20hrs/wk x 50wks	\$20,000
Travel 590 miles @ .44 cents/mile	260
Supplies	500
Total	\$20,760

Example B. Fee for Service:

Develop and Produce	
500 Videos @ \$10 each	\$5,000
Total	

Example C. Hourly Rate:

Quality Assurance Review of 200 Patient Charts	
by Nurse Clinician 200 hours @ \$25/hour	\$5,000
Total	\$5,000

*****Please note: If Laboratory Services is a line item or subcontractor, please supply a justification as to why a private laboratory is being used as opposed to the Connecticut State Laboratory.**

APPLICATION FORMS

Category	Amount
Personnel:	
1) Name & Position: _____ , _____	
Calculation: _____	
Fringe Benefit: _____ %	
2) Name & Position: _____ , _____	
Calculation: _____	
Fringe Benefit: _____ %	
3) Name & Position: _____ , _____	
Calculation: _____	
Fringe Benefit: _____ %	
4) Name & Position: _____ , _____	
Calculation: _____	
Fringe Benefit: _____ %	
5) Name & Position: _____ , _____ :	
Calculation: _____	
Fringe Benefit: _____ %	
6) Travel _____ per mile X _____ miles	
7) Training	
8) Educational Materials	
9) Office Supplies	
10) Medical Materials	
11) Contractual (Subcontracts)***	
12) Telephone	
13) Advertising	
14) Other Expenses (List Below)	
a)	
b)	
c)	
d)	
e)	
f)	
15) Administrative and General Costs	
Total DPH Grant	
Other Program Income:	

*** Complete Subcontractor Schedule A

APPLICATION FORMS

**Subcontractor Schedule A-Detail
#1**

Program:

Subcontractor Name:

Address:

Telephone: () (-)

Select One: **A** Budget Basis **B** Fee-for-Service **C** Hourly Rate

Indicate One: MBE WBE Neither

Line Item	Amount
Total Subcontract Amount:	

#2

Subcontractor Name:

Address:

Telephone: () (-)

Select One: **A** Budget Basis **B** Fee-for-Service **C** Hourly Rate

Indicate One: MBE WBE Neither

Line Item	Amount
Total Subcontract Amount:	

#3

Subcontractor Name:

Address:

Telephone: () (-)

Select One: **A** Budget Basis **B** Fee-for-Service **C** Hourly Rate

Indicate One: MBE WBE Neither

Line Item	Amount
Total Subcontract Amount:	

APPLICATION FORMS

E. Work plan (make as many blank pages as needed)

Services to be Provided Measurable Objectives	Activities	Staff Position(s) Responsible	Expected Outcomes and Measures of Success	Timetable

APPLICATION FORMS

F. Staffing

Profile of Staff Providing Services (see Section E of this RFP). Please provide the information requested below.

Professional Staff*	Name	Title	Hourly Rate	Assigned to Project: # hrs/wk
Position 1				
Position 2				
Position 3				
Position 4				
Clerical/ Support Staff:				
Position 1				
Position 2				

***Attach Resumes for all Professional Staff**

APPLICATION FORMS

G. Assurances

Any prospective contractor must agree to adhere to the following conditions and **must positively state such in the proposal. Please read, sign, date, and return this statement with your proposal.**

- A. **Conformance with Statutes** - Any contract awarded as a result of this RFP must be in full conformance with statutory requirements of the State of Connecticut and the Federal Government.
- B. **Ownership of Proposals** - All proposals in response to this RFP are to be the sole property of the State, and subject to the provisions of Sections 1-19 of the Connecticut General Statutes (Re: Freedom of Information).
- C. **Reports and Information** - The contractor shall agree to supply any information required by DPH: including evaluation and billing information in the time, manner, and format directed by DPH.

The contractor shall permit access by properly authorized DPH staff to the contractor's premises, staff and participant and financial records, at any reasonable time.

The right to publish, distribute or disseminate any and all information or reports, or any part thereof, shall accrue to DPH without recourse. The contractor shall maintain written records to substantiate costs incurred under the contract.

- D. **Timing and Sequence** – The timing and sequence of events resulting from this RFP will ultimately be determined by the State.
- E. **Stability of Proposed Prices** - Any price offerings from applicants must be valid for a period of 120 days from the due date of applicant proposals.
- F. **Oral Agreements** - Any alleged oral agreement or arrangement made by an applicant with any agency or employee will be superseded by the written agreement.
- G. **Amending or Canceling Requests** - The State reserves the right to amend or cancel this RFP at its discretion, prior to the due date and time, and/or at any point to the issuance of the written agreement, if it is in the best interests of the agency and the State.
- H. **Rejection for Default or Misrepresentation** - The State reserves the right to reject the proposal of any applicant which is in default of any prior contract or for misrepresentation.

APPLICATION FORMS

- I. **State's Clerical Errors in Awards** - The State reserves the right to correct inaccurate awards resulting from its clerical errors.
- J. **Rejection of Proposals** - Proposals are subject to rejection in whole or in part if they limit or modify any of the terms and conditions and/or specifications of the RFP.
- K. **Applicant Presentation of Supporting Evidence** - An applicant, if requested, must be prepared to present evidence of experience, ability, service facilities, and financial standing necessary to satisfactorily meet the requirements set forth or implied in the RFP.
- L. **Changes to Proposals** - No additions or changes to the original proposal will be allowed after submittal, unless specifically requested by DPH.
- M. **Collusion** - By responding, the applicant implicitly states that the proposal is not made in connection with any competing applicant submitting a separate response to the RFP, and is in all respects fair and without collusion or fraud. It is further implied that the applicant did not participate in the RFP development process, had no knowledge of the specific contents of the RFP prior to its issuance, and that no employee of the agency participated directly or indirectly in the applicant's proposal preparation.
- N. **Subcontracting** - In a multi-contractor situation, DPH requires a single point of responsibility and accountability.

The undersigned acknowledges receiving and reading the aforementioned assurances and agrees to these terms and conditions as set forth by the Department of Public Health.

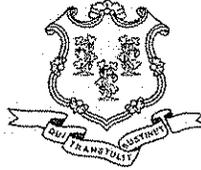
Signature

Date

On behalf of:

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

J. Robert Galvin, M.D., M.P.H.
Commissioner



M. Jodi Rell
Governor

AFFIRMATIVE ACTION
CONTRACT COMPLIANCE POLICY STATEMENT

The Department of Public Health is an affirmative action employer, in compliance with all state and federal laws which prohibit discrimination and mandate affirmative action to overcome the present effects of past discrimination. Accordingly, we require that the individuals and organizations with which we do business do not engage in discriminatory practices.

This Department and our contractors shall fully comply with the CONTRACT COMPLIANCE REGULATIONS OF CONNECTICUT STATE AGENCIES, Sections 46a-68j-21 through 46a-68j-43, which establish procedures for evaluating compliance with Connecticut General Statutes, Section 4a-60, the state's nondiscrimination contract provisions. We require our contractors to cooperate with the Connecticut Commission on Human Rights and Opportunities in all activities pertinent to these regulations.

This Department will not knowingly do business with any contractor, subcontractor or supplier of materials who unlawfully discriminates against members of any class protected under state or federal law. Contractors whose overall employment statistics are not reflective of the general employment area may be required to submit evidence of good faith efforts to ensure that their personnel policies and practices do not have a discriminatory impact.

As part of our contract compliance program, bidders, contractors, subcontractors, and suppliers are encouraged to develop and follow a plan of affirmative action to achieve or exceed parity of employment with the applicable labor market. The existence and active administration of voluntary plans will be a factor in deciding contract approvals and the continuation of existing contracts, in accordance with Section 46a-68j-30.

This Department also solicits and encourages the participation of minority business enterprises as bidders, awardees, contractors, suppliers, and subcontractors.

All bidders and contractors shall be notified of this policy, must sign a Notification to Bidders Form, and complete a workforce analysis questionnaire necessary for the contract award process.

17 Sep 04
Date

J. Robert Galvin
J. Robert Galvin, M.D., M.P.H.
Commissioner of Public Health



PHONE: (860) 509-7101 FAX: (860) 509-7111
410 CAPITOL AVENUE - MS#13COM, P.O. BOX 340308, HARTFORD, CONNECTICUT 06134-0308
Affirmative Action/Equal Employment Opportunity Employer

APPLICATION FORMS

NOTIFICATION TO BIDDERS

The contract to be awarded is subject to contract compliance requirements mandated by Sections 4a-60 and 4a-60a of the Connecticut General Statutes; and, when the awarding agency is the State, Sections 46a-71 (d) and 46a-81i (d) of the Connecticut General Statutes. There are Contract Compliance Regulations codified at Section 46a-68j-21 through 46a-68j-43 of the Regulations of Connecticut State agencies, which establish a procedure for the awarding of all contracts covered by Sections 4a-60 and 46a-71 (d) of the Connecticut General Statutes.

According to Section 46a-68j-30 (9) of the Contract Compliance Regulations, every agency awarding a contract subject to the contract compliance requirements has an obligation to "aggressively solicit the participation of legitimate minority business enterprises as bidders, contractors, subcontractors and suppliers of materials." "Minority Business Enterprise" is defined in Section 4a-60 of the Connecticut General Statutes as a business wherein fifty-one percent or more of the capital stock, or assets belong to a person or persons: "(1) Who are active in the daily affairs of the enterprise; (2) Who have the power to direct the management and policies of the enterprise; and, (3) Who are members of a minority, as such term is defined in subsection (a) of Section 32-9n." "Minority" groups are defined in Section 32-9n of the Connecticut General Statutes as "(1) Black Americans ... (2) Hispanic Americans ... (3) Women ... (4) Asian Pacific Americans and Pacific Islanders; or (5) American Indians." The above definitions apply to the contract compliance requirements by virtue of Section 46a-68j-21 (11) of the Contract Compliance Regulations.

The awarding agency will consider the following factors when reviewing the bidder's qualifications under the contract compliance requirements.

- a) the bidder's success in implementing an affirmative action plan;
- b) the bidder's success in developing an apprenticeship program complying with Sections 46a-68-1 to 46a-68-18 of the Connecticut General Statutes, inclusive;
- c) the bidder's promise to develop and implement a successful affirmative action plan;
- d) the bidder's submission of EEO-1 data indicating the composition of its workforce is at or near parity when compared to the racial and sexual composition of the workforce in the relevant labor market area; and,
- e) the bidder's promise to set aside a portion of the contract for legitimate minority business enterprises. See Section 46a-68j-30 (10) (E) of the Contract Compliance Regulations.

INSTRUCTION: Bidder must sign acknowledgment below line and return acknowledgment to Awarding Agency along with the bid proposal.

The undersigned acknowledges receiving and reading a copy of the "Notification to Bidders" form.

Signature

Date

On behalf of:

WORKFORCE ANALYSIS

Contractor Name:
Address:

Total Number of CT employees:
Full Time:

Part Time:

Complete the following Workforce Analysis for employees on Connecticut workites who are:

Job Categories	Overall Totals (sum of all cols. male & female)		White (not of Hispanic Origin)		Black (not of Hispanic Origin)		Hispanic		Asian or Pacific Islander		American Indian or Alaskan Native		People with Disabilities	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Officials & Managers														
Professionals														
Technicians Office & Clerical														
Craft Workers (skilled)														
Operatives (semi-skilled)														
Laborers (unskilled)														
Service Workers														
Totals Above														
Totals 1 year Ago														
FORMAL ON-THE-JOB TRAINEES (Enter figures for the same categories as are shown above)														
Apprentices														
Trainees														
EMPLOYMENT FIGURES WERE OBTAINED FROM:										Visual Check:		Employment Records		Other:

1. Have you successfully implemented an Affirmative Action Plan? YES NO

Date of implementation: _____ If the answer is "No", explain.

1. a) Do you promise to develop and implement a successful Affirmative Action?

YES NO Not Applicable Explanation:

2. Have you successfully developed an apprenticeship program complying with Sec. 46a-68-1 to 46a-68-18 of the Connecticut Department of Labor Regulations, inclusive: YES NO Not Applicable Explanation:

3. According to EEO-1 data, is the composition of your work force at or near parity when compared with the racial and sexual composition of the work force in the relevant labor market area? YES NO Explanation:

if you plan to subcontract, will you set aside a portion of the contract for legitimate minority business enterprises? YES NO

Explanation: _____

Contractor's Authorized Signature _____ Date _____

Appendix B - Non-Discrimination Provisions for State of Connecticut Contracts*

*Note: Appendix B is provided for your information only. The forms in this Appendix do not need to be completed for the RFP. These will be used for applicants awarded funding and requested during the contract development process.

The Office of the Attorney General has approved the following nondiscrimination certification forms to assist executive branch agencies in complying with the State of Connecticut's contracting requirements, pursuant to the Connecticut General Statutes § 4a-60(a)(1) and § 4a-60a(a)(1), as amended by Public Act 07-245 and Sections 9 and 10 of Public Act 07-142.

By law, a contractor must provide the State with documentation in the form of a company or corporate policy adopted by resolution of the board of directors, shareholders, managers, members or other governing body of such contractor to support the nondiscrimination agreement and warranty under C.G.S. §§ 4a-60a and 46a-68h.

The first of these forms is designed to be used by corporate or other business entities; the **second is to be used only by individuals** who are to sign and perform contracts with the State in their individual capacity. One or the other of these certifications is required for all State contracts, regardless of type, term, cost, or value. Pursuant to C.G.S. § 46a-56(b), State agencies may apply to the Commission on Human Rights and Opportunities (CHRO) for a waiver from this requirement when entering into contracts with the entities listed below:

- municipalities or other political subdivisions of the State;
- quasi-public State agencies;
- other state governments (including the District of Columbia);
- the federal government;
- U.S. territories and possessions;
- federally recognized Indian tribal governments; and
- foreign governments.

The appropriate certification must be signed by an authorized signatory of the contractor (or, in the case of an individual contractor, by the individual) and submitted to the awarding State agency at the time of contract execution. The appropriate form is required for all contracts signed on and after June 25, 2007.

Non-discrimination Regarding Sexual Orientation. Unless otherwise provided by Conn. Gen. Stat. § 46a-81p, the Contractor agrees to the following provisions required pursuant to § 4a-60a of the Connecticut General Statutes:

- (a)(1) The Contractor agrees and warrants that in the performance of the Contract such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of sexual orientation, in any manner prohibited by the laws of the United States or of the State of Connecticut, and that employees are treated when employed without regard to their sexual orientation;
 - (2) the Contractor agrees to provide each labor union or representatives of workers with which such Contractor has a collective bargaining agreement or other Contract or understanding and each vendor with which such Contractor has a Contract or understanding a notice to be provided by the commission on human rights and opportunities advising the labor union or workers' representative of the Contractor's commitments under this section, and to post copies of the notice in conspicuous places available to employees and applicants for employment;
 - (3) the Contractor agrees to comply with each provision of this section and with each regulation or relevant order issued by said commission pursuant to § 46a-56 of the Connecticut General Statutes;
 - (4) the Contractor agrees to provide the commission on human rights and opportunities with such information requested by the commission, and permit access to pertinent books, records and accounts concerning the employment practices and procedures of the Contractor which relate to provisions of this section and § 46a-56 of the Connecticut General Statutes.
- (b) The Contractor shall include the provisions of subsection (a) of this section in every subcontract or purchase order entered into in order to fulfill any obligation of a Contract with the state and such provisions shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the commission may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with § 46a-56 of the Connecticut General Statutes provided, if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the commission, the Contractor may request the State of Connecticut to enter into any such litigation or negotiation prior thereto to protect the interests of the state and the state may so enter.

Nondiscrimination and Affirmative Action Provisions in Contracts of the State and Political Subdivisions Other Than Municipalities. The Contractor agrees to comply with provisions of § 4a-60 of the Connecticut General Statutes:

- (a) Every Contract to which the state or any political subdivision of the state other than a municipality is a party shall contain the following provisions:
- (1) The Contractor agrees and warrants that in the performance of the Contract such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, religious creed, age, marital status, national origin, ancestry, sex, mental retardation or physical disability, including, but not limited to, blindness, unless it is shown by such Contractor that such disability prevents performance of the work involved, in any manner prohibited by the laws of the United States or of the state of Connecticut. The Contractor further agrees to take affirmative action to insure that applicants with job-related qualifications are employed and that employees are treated when employed without regard to their race, color, religious creed, age, marital status, national origin, ancestry, sex, mental retardation, or physical disability, including, but not limited to, blindness, unless it is shown by such Contractor that such disability prevents performance of the work involved;
 - (2) the Contractor agrees, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, to state that is an "affirmative action-equal opportunity employer" in accordance with regulations adopted by the commission;
 - (3) the Contractor agrees to provide each labor union or representative of workers with which such Contractor has a collective bargaining agreement or other Contract or understanding and each vendor with which such Contractor has a Contract or understanding, a notice to be provided by the commission advising the labor union or workers' representative of the Contractor's commitments under this section, and to post copies of the notice in conspicuous places available to employees and applicants for employment;
 - (4) the Contractor agrees to comply with each provision of this section and Conn. Gen. Stat. §§ 46a-68e and 46a-68f and with each regulation or relevant order issued by said commission pursuant to Conn. Gen. Stat. §§ 46a-56, 46a-68e and 46a-68f;
 - (5) the Contractor agrees to provide the commission of human rights and opportunities with such information requested by the commission and permit access to pertinent books, records and accounts, concerning the employment practices and procedures of the Contractor as relate to the provisions of this section and Conn. Gen. Stat. § 46a-56. If the Contract is a public works Contract, the Contractor agrees and warrants that he will make good faith efforts to employ minority business enterprises as subcontractors and suppliers of materials on such public works project.

(b) For the purposes of this section, "minority business enterprise" means any small Contractor or supplier of materials fifty-one per cent or more of capital stock, if any, or assets of which is owned by a person or persons:

- (1) who are active in the daily affairs of the enterprise;
- (2) who have the power to direct the management and policies of the enterprise; and
- (3) who are members of a minority, as such term is defined in subsection (a) of Conn. Gen. Stat. § 49-60g.

(c) For the purposes of this section, "good faith" means that degree of diligence, which a reasonable person would exercise in the performance of legal duties and obligations. "Good faith efforts" shall include, but not be limited to, those reasonable initial efforts necessary to comply with statutory or regulatory requirements and additional or substituted efforts when it is determined that such initial efforts will not be sufficient to comply with such requirements. Determinations of the Contractor's good faith efforts shall include but shall not be limited to the following factors: The Contractor's employment and subcontracting policies, patterns and practices; affirmative action advertising; recruitment and training; technical assistance activities and such other reasonable activities or efforts as the commission may prescribe that are designed to ensure the participation of minority business enterprises in public works projects.

(d) The Contractor shall develop and maintain adequate documentation, in a manner prescribed by the commission, of its good faith efforts.

(e) Contractor shall include the provisions of subsection (a) of this section in every subcontract or purchase order entered into in order to fulfill any obligation of a Contract with the state and such provision shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the commission may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with Conn. Gen. Stat. § 46a-56; provided, if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the commission, the Contractor may request the state of Connecticut to enter into such litigation or negotiation prior thereto to protect the interests of the state and the state may so enter.

NONDISCRIMINATION CERTIFICATION

(By corporate or other business entity regarding support of nondiscrimination against persons on account of their race, color, religious creed, age, marital or civil union status, national origin, ancestry, sex, mental retardation, physical disability or sexual orientation.)

I, Non-Discrimination Provisions for State of CT Contract signer's name, signer's title, of name of entity, an entity lawfully organized and existing under the laws of name of state or commonwealth, do hereby certify that the following is a true and correct copy of a resolution adopted on the ____ day of ____, 20____ by the governing body of name of entity, in accordance with all of its documents of governance and management and the laws of name of state or commonwealth, and further certify that such resolution has not been modified, rescinded or revoked, and is, at present, in full force and effect.

RESOLVED: That name of entity hereby adopts as its policy to support the nondiscrimination agreements and warranties required under Connecticut General Statutes § 4a-60(a)(1) and § 4a-60a(a)(1), as amended in State of Connecticut Public Act 07-245 and sections 9(a)(1) and 10(a)(1) of Public Act 07-142.

WHEREFORE, the undersigned has executed this certificate this ____ day of ____, 20____.

Signature

NONDISCRIMINATION CERTIFICATION

(By individual contractor regarding support of nondiscrimination against persons on account of their race, color, religious creed, age, marital or civil union status, national origin, ancestry, sex, mental retardation, physical disability or sexual orientation.)

I, signer's name, of business address, am entering into a contract (or an extension or other modification of an existing contract) with the State of Connecticut (the "State") in my individual capacity for if available, insert "Contract No. _____"; otherwise generally describe goods or services to be provided. I hereby certify that I support the nondiscrimination agreements and warranties required under Connecticut General Statutes Sections 4a-60(a)(1) and 4a-60a(a)(1), as amended in State of Connecticut Public Act 07-245 and sections 9(a)(1) and 10(a)(1) of Public Act 07-142.

WHEREFORE, I, the undersigned, have executed this certificate this _____ day of _____, 20_____.

Signature

MINIMUM REQUIREMENTS CHECKLIST

ATTACHMENT D

Applicant

1. Resumes provided for all professional staff assigned to this project _____
2. Completed Notification to Bidders form included in proposal _____
3. Completed Workforce Analysis Questionnaire included in proposal _____
4. Signed Statement of Adherence to Assurances included in proposal _____
5. An original and 5 copies of the completed proposal must be received at DPH no later than September 19, 2012 _____
6. Proposal is completed on Application Forms included in Attachment A _____
7. The proposal is signed by an authorized official of the Applicant Organization. _____

TECHNICAL REVIEW WORKSHEET

ATTACHMENT E

Applicant

CRITERIA

	<u>Maximum Points*</u>	<u>Bidder's Points</u>
1. The applicant has demonstrated successful experience providing similar services	(5)	_____
2. The references provided support the applicant's success in providing similar services, including but not limited to case management, screening and diagnostic follow-up, treatment referrals, risk reduction counseling, and tracking systems	(5)	_____
3. The profile of staff who will be working on this project is clear and qualified to initiate, manage, and implement the services to be provided	(20)	_____
4. The extent to which the CIHSP Community Advisory Council role membership and responsibilities are clearly described;	(10)	_____
5. A thorough Work Plan is presented with measurable objectives that addresses key program components and specific timelines	(20)	_____
6. A cost effective budget is presented which follows eligibility guidelines	(15)	_____
7. The budget identifies the type and amount of in-kind resources	(5)	_____
8. The budget identifies the number of participants to be screened	(5)	_____
9. The budget identifies the cost per participant screened	(5)	_____
10. The applicant provides evidence that it will utilize small and minority businesses Whenever feasible and appropriate in the purchase of supplies and services funded through this contract	(5)	_____
11. The budget is fiscally competitive.	(5)	_____