STATE OF CONNECTICUT

REQUEST FOR PROPOSALS

Medical Care Management
Administrative Services Organization

DEPARTMENT OF SOCIAL SERVICES

April 5, 2011

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SECTION I: OVERVIEW

A. DEFINITIONS

As used throughout this RFP, the following terms shall have the meanings set forth below:

A.1. Action: Abuse: Provider and/or Contractor practices inconsistent with sound fiscal, business or medical practices that result in an unnecessary cost to the State of Connecticut, or a pattern of failing to provide medically necessary services required by this RFP and subsequent contract. Member practices that result in unnecessary cost to the State of Connecticut also constitute abuse.

A.2. Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service in specific circumstances; the failure to provide services in a timely manner, as defined by the DEPARTMENT; and the failure of an MCO to act within the timeframes for authorization decisions set forth in this contract.

A.3. Acute Services: Medical or behavioral health services needed for an illness, episode, or injury that requires intense care, and hospitalization.

A.4. Ad-hoc Report: A report that has not been previously produced and which may require specifications to be written, development and testing prior to production to complete.

A.5. Administrative Hearing: Also called Fair Hearing. A proceeding during which a Medicaid client presents his or her claim to an impartial hearing officer at the Department of Social Services that the Department failed to take action within a required period of time or acted erroneously with regard to coverage of services. Claims relating to coverage of service include the Department's or Contractor's decision to deny, reduce, suspend or terminate services or to authorize a level of care that the member believes is inappropriate.

A.6. Administrative Services Organization (ASO): an organization or organizations providing utilization management benefit information and intensive care management services within a centralized information system framework.

A.7. Adverse Determination: A determination by a HUSKY B or Charter Oak MCO that an admission, service, procedure, or extension of stay that is a covered benefit has been reviewed and based upon the information provided, does not meet the DEPARTMENT'S requirements for medical necessity and such requested admission, service, procedure or extension of stay or payment for such admission, service, procedure or extension of stay, has been denied,

reduced or terminated. In the context of HUSKY B and Charter Oak, an adverse determination is also called a "denial."

A.8. Annual Benefit Maximum: The maximum amount of $100,000 for all goods and services covered by the Charter Oak Health Plan applied on an annual basis starting from the first day of the enrollee's eligibility period.

A.9. ASO Appeal: A procedure through which members or providers can request a re-determination of an ASO decision concerning, but not limited to service authorization

A.10. Adult: Person 18 years of age or older.

A.11. Advanced Practice Registered Nurse (APRN): A master's level registered nurse with a certification that allows for the prescribing of medications.

A.12. Agent: An entity with the authority to act on behalf of the Department.

A.13. Automated Eligibility Verification System (AEVS): The sole comprehensive source of the Department of Social Services' client eligibility information. The following electronic methods can be used to verify client eligibility: Automated Voice Response System (AVRS), HP's Provider Electronic Solutions (PES) software, and vendor software utilizing the ASC X12N 270/271: Health Care Eligibility/Benefit Inquiry and Information Response transaction.

A.14. Behavioral Health Partnership ("CT BHP"): An integrated behavioral health service system developed and managed by the Commissioners of Social Services, Children and Families, and Mental Health and Addition Services. The BHP has served HUSKY Part A and HUSKY Part B members, children enrolled in the Voluntary Services Program operated by the Department of Children and Families and, at the discretion of the Commissioners of Children and Families and Social Services, other children, adolescents, and families served by the Department of Children and Families. Effective April 1, 2011, the CT BHP is being expanded to include, Medicaid clients in the aged, blind and disabled coverage groups, Medicaid for Low-Income Adults clients and Charter Oak Health Plan members.

A.15. Behavioral Health Services: Services that are necessary to diagnose, correct or diminish the adverse effects of a psychiatric or substance use disorder.

A.16. Bypass Program: A program for high performing providers that enables them to bypass the usual utilization management requirements and instead fulfill prior authorization requirements through a notification process.

A.17. Care Coordinator: An independently licensed health care clinician employed by the Contractor, who works with providers and members to facilitate organization

of care, and facilitates the exchanging of information among participants in a member's care plan.

A.18. Care Manager: An independently licensed clinician employed by the Contractor to perform utilization review on services that require prior authorization and concurrent review.

A.19. Case Management: Services whose primary aim is assessment, evaluation, planning, linkage, support and advocacy to assist individuals in gaining access to needed medical, social, educational or other services.

A.20. Case Managers: Paraprofessionals whose responsibilities include outreach, engagement, linkage, advocacy, and monitoring of assigned cases.

A.21. Centers for Medicare and Medicaid Services (CMS): The Centers for Medicare and Medicaid Services (CMS) is a division within the United States Department of Health and Human Services. CMS oversees the Medicaid and Children's Health Insurance Program (CHIP) programs...

A.22. The Charter Oak Health Plan: A publicly-funded program that, pursuant to Connecticut General Statutes § 17b-311, provides access to health insurance coverage for Connecticut residents who have been uninsured for at least six (6) months and who are ineligible for Medicare, HUSKY A, and HUSKY B or other publicly-funded health insurance.

A.23. Children: Individuals under eighteen (18) years of age.

A.24. Children and Youth With Special Healthcare Needs: Children and youth with special health care needs are those who have or who are at an increased risk for chronic physical, developmental, behavioral, or emotional conditions and require health and related (not educational or recreational) services beyond that required for children in general (U.S. Maternal and Child Health Bureau)..

A.25. CHIP (Children's Health Insurance Program): Services provided in accordance with Title XXI of the federal Social Security Act. Formally called "SCHIP" (State Children's Health Insurance Program).

A.26. Chronic Disease Hospital: Per Conn. Agencies Reg. § 19-13-D1 (b) (2), a chronic disease hospital is defined as a "long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of a wide range of chronic diseases."

A.27. Clinical Management: The process of evaluating and determining the appropriateness of the utilization of health services as well as providing assistance to clinicians or members to ensure appropriate use of resources. It may include, but is not limited to, prior authorization, concurrent review, and retroactive medical necessity review; discharge review; retrospective utilization

review; quality management; provider certification; and provider performance enhancements.

A.28. Clinician: Unless otherwise designated by the Department, a person who is licensed to practice independently in the State of Connecticut.

A.29. Committed: Placed under the custody of the Commissioner of the Department of Children and Families (DCF), pursuant to a valid court order issued by a court of competent jurisdiction.

A.30. Complaint: A written or oral communication to the Contractor from an individual expressing dissatisfaction with some aspect of the Contractor's services.

A.31. Concurrent Review: Review of the medical necessity and appropriateness of medical services on a periodic basis during the course of treatment.

A.32. Connecticut Medical Assistance Program (CMAP): The Connecticut Medical Assistance Program consists of several medical programs administered by the Department of Social Services and the provider network that serves these programs. The programs include: Medicaid (also known as Title XIX), several Medicaid waiver programs, the Connecticut Behavioral Health Partnership (CT BHP), Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE), Health Insurance for Uninsured Kids and Youth (HUSKY) A & B, Connecticut AIDS Drug Assistance Program (CADAP), Connecticut Dental Health Partnership, and the Charter Oak Health Plan.

A.33. Consultant: A corporation, company, organization or person or their affiliates retained by the Department to provide assistance in this project or any other project; not the Contractor or subcontractor.

A.34. Contract Administrator: The State of Connecticut employee designated by the Department to fulfill the administrative responsibilities associated with this RFP and subsequent contract.

A.35. Contract Services: Those services that the Contractor is required to provide under this RFP and subsequent contract.

A.36. Contractor: An Administrative Services Organization providing case management, benefit information, member services, quality management, and other administrative services outlined in this RFP and subsequent contract within a centralized information system framework.

A.37. Current Procedural Terminology (CPT): Current Procedural Terminology codes published by the American Medical Association.

A.38. Critical Incident/Significant Event: Any incident that results in serious injury, or risk thereof, serious adverse treatment response, death of a service user, or

serious impact on service delivery as defined by the Department's policies and procedures.

A.39. Data Warehouse: A data storage system or systems constructed by consolidating information currently being tracked on different systems by different contractors of the Department.

A.40. Date of Application: The date on which a completed Medical Assistance application is received by the Department of Social Services, or its agent, containing the applicant's signature.

A.41. Day: Except where the term "business days" is expressly used, all references in this RFP will be construed as calendar days.

A.42. Denial of Authorization: Any rejection, in whole or in part, of a request for authorization from a provider on behalf of a member.

A.43. Dental Health Partnership ("CT DHP"): An integrated dental health service system developed and managed by the Commissioner of Social Services.

A.44. Department: The Department of Social Services (DSS) or its agents.

A.45. Department of Children and Families (or DCF): Pursuant to Conn. Gen. Stat. § 17a-2, the Connecticut Department of Children and Families (DCF) offers child protection, behavioral health, juvenile justice and prevention services to (i) abused and neglected children, (ii) children committed to DCF by the juvenile justice system; and (iii) families of these and other at-risk children. Additional information is available online at www.ct.gov/dcf/site/default.asp

A.46. Department of Developmental Services (DDS): Department of Developmental Services" or "DDS" means the state agency responsible for the planning, development and administration of complete, comprehensive and integrated state-wide services for persons with mental retardation, including the operation of the Home and Community Based Service waivers for individuals with mental retardation or who are otherwise eligible for such services.

A.47. Department of Mental Health and Addiction Services (DMHAS): Pursuant to Conn. Gen. Stat. § 17a-450, Department of Mental Health and Addiction Services (DMHAS) promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment throughout Connecticut.

A.48. Diagnostic and Statistical Manual of Mental Disorders (DSM, most recent edition): The American Psychiatric Association's current listing of descriptive terms and identifying codes for reporting a classification of mental and substance abuse disorders.

A.49. Discharge Planning: Activities that facilitate a patient's movement from one health care setting to another or to home. Discharge planning is a multidisciplinary process, involving the patient and his or her family, physicians, nurses, social workers and possibly other health care professionals. The process begins on admission and is aimed at enhancing continuity of care.

A.50. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Comprehensive child health care services to HUSKY A members under twenty-one (21) years of age, including all medically necessary prevention, screening, diagnosis and treatment services listed in Section 1905 (r) of the Social Security Act.

A.51. EPSDT Case Management Services: Services such as making and facilitating referrals and development and coordination of a plan of services that will assist members under twenty-one (21) years of age in gaining access to needed medical, social, educational, and other services.

A.52. EPSDT Diagnostic and Treatment Services: All health care, diagnostic services, and treatment necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by an interperiodic or periodic EPSDT screening examination.

A.53. EPSDT Screening Services: Comprehensive, periodic health examinations for members under the age of twenty-one (21) provided in accordance with the requirements of the federal Medicaid statute at 42 U.S.C. § 1396d(r) (1).

A.54. EPSDT Special Services: As required by 42 U.S.C. § 1396(r)(5), other health care, diagnostic services, preventive services, rehabilitative services, treatment, or other measures described in 42 U.S.C. 1396d(a), that are not otherwise covered under the Connecticut Medicaid Program and that are medically necessary.

A.55. Eligible: Eligible means that the individual has been approved or is entitled to services under one of the Department's Medical Assistance programs.

A.56. Eligibility Management System (EMS): An automated system operated by the Department of Social Services (DSS) for maintaining eligibility information regarding Medicaid, Medicaid for Low Income Adults, CADAP, HUSKY A, Waiver Programs, DCF funded clients or Voluntary Services members. It also provides fully integrated data processing support for benefit calculation and issuance, financial accounting, and management reporting.

A.57. Emergency or Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant

woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any body organ or part.

A.58. Emergency Services: Inpatient and outpatient services needed to evaluate or stabilize an emergency medical condition.

A.59. Enrollment Broker: An entity contracted by the Department of Social Services to perform certain administrative and operational functions for the Charter Oak Health Plan, HUSKY A and HUSKY B programs that may include HUSKY application processing, HUSKY B eligibility determinations or other functions as required by the Department.

A.60. Explanation of Benefits (EOB): The remittance advice received by the provider, which details how the service was adjudicated.

A.61. Family: Family means a member together with (A) one or more biological or adoptive parents, except for a parent whose parental rights have been terminated, (B) one or more persons to whom legal custody or guardianship has been given, or (C) one or more adults, including foster parents, who have a primary responsibility for providing continuous care to such child or youth; or the close relatives of an adult including but not limited to parents, children, spouse or domestic partner. For adults, family is considered an individual or individuals who are part of the member's immediate or extended family.

A.62. Federal Poverty Level: The poverty guidelines updated annually in the Federal Register by the U.S. Department of Health & Human Services under authority of 42 U.S.C. § 9902.

A.63. Fraud: Intentional deception or misrepresentation, or reckless disregard or willful blindness, by a person or entity with the knowledge that the deception, misrepresentation, disregard or blindness could result in some unauthorized benefit to himself or some other person, including any act that constitutes fraud under applicable federal or state law.

A.64. Grievance: An expression of dissatisfaction on any matter other than an "action" or "adverse determination" as defined herein. A grievance is commonly referred to as a "complaint." Possible subjects for grievances include, but are not limited to, the quality of care or services provided by the MCO and aspects of interpersonal relationships such as rudeness of a provider or an MCO employee, or failure to respect a member's rights.

A.65. Health Home (HH) : As defined in Section 1945(h)(4) of the Affordable Care Act, the term "health home" means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services. Health home services include: (i) comprehensive care

management; (ii) care coordination and health promotion; (iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; (iv) patient and family support (including authorized representatives); (v) referral to community and social support services, if relevant; and (vi) use of health information technology to link services, as feasible and appropriate..

A.66. Healthcare Common Procedure Coding System (HCPCS): A system of national health care codes that includes the following: Level I is the American Medical Association Physician's Common Procedural Terminology (CPT codes). Level II covers services and supplies not covered in CPT. Level III includes local codes used by state Medicare carriers.

A.67. Healthcare Effectiveness Data and Information Set (HEDIS): A standardized performance measurement tool promulgated by the National Committee for Quality Assurance (NCQA) that enables users to evaluate quality based on the following categories: effectiveness of care; contractor stability; use of services; cost of care; informed health care choices; and contractor descriptive information.

A.68. Home Health Care Services: Services provided by a home health care agency (as defined in Subsection d of section 19A-4890 of Connecticut General Statutes) that is licensed by the Department of Public Health, meets the requirements for participation in Medicare and meets all of the Department's enrollment requirements.

A.69. HP Enterprise Services (HP) formerly EDS: The Department of Social Service's fiscal agent contracted to operate a Medicaid Management Information System (MMIS) which adjudicates and processes claims, includes an eligibility verification system, and supports other related functions, and to provide related support services such as enrollment of providers, client and provider call centers, and other ancillary services to support the Connecticut Medical Assistance Program

A.70. HUSKY, Part A or HUSKY A: Connecticut's implementation of managed care health insurance under the federal Medicaid program (Title XIX) for children, parents or relative caretakers. Eligibility is for families earning below 185% as well as pregnant women under 250% of the federal poverty level and other groups pursuant to Section 17b-266 of the Connecticut General Statutes.

A.71. HUSKY, Part B or HUSKY B: The health insurance plan for children and youth, up to the age of nineteen, established pursuant to Title XXI (CHIP) of the Social Security Act, the provisions of Sections 17b-289 to 17b-303, inclusive, of the Connecticut General Statutes, and Section 16 of Public Act 97-1 of the October special session. This program provides subsidized health insurance for uninsured children in families earning from 185% to 300% of the federal poverty level. Unsubsidized coverage is available under HUSKY B for families earning more than 300% of the federal poverty level.

A.72. HUSKY Plus Physical Program (or HUSKY Plus Program): A supplemental physical health program pursuant to Conn. Gen. Stat. § 17b-294, for medically eligible members of HUSKY B in Income Bands 1 and 2, whose intensive physical health needs cannot be accommodated within the HUSKY Plan, Part B.

A.73. Implementation: The date on which the Contractor assumes responsibility for the management of medical benefits for members.

A.74. Implementation Review: An on-site review to determine whether the Contractor has achieved sufficient implementation progress to operate its administrative services by such time as indicated in the Contractor's approved Implementation Plan.

A.75. Income Bands: For the purposes of the HUSKY B or Charter Oak Programs, members who are in families with the following countable incomes:

A.76. Income Band 1: For purposes of HUSKY B, members who are in families with countable incomes over 185% and up to and including 235% of the federal poverty level.

A.77. Income Band 2: For purposes of HUSKY B, members who are in families with countable incomes over 235% and up to and including 300% of the federal poverty level.

A.78. Income Band 3: For purposes of HUSKY B, members who are in families with countable incomes over 300% of the federal poverty level.

A.79. Income Band C1: For purposes of Charter Oak, members who are in families with countable incomes up to and including 150% of the federal poverty level.

A.80. Income Band C2: For purposes of Charter Oak, members who are in families with countable incomes over 150% and up to and including 185% of the federal poverty level.

A.81. Income Band C3: For purposes of Charter Oak, members who are in families with countable incomes over 185% and up to and including 235% of the federal poverty level.

A.82. Income Band C4: For purposes of Charter Oak, members who are in families with countable incomes over 235% and up to and including 300% of the federal poverty level.

A.83. Income Band C5: For purposes of Charter Oak, members who are in families with countable incomes over 300% of the federal poverty level.

A.84. Inpatient: Inpatient refers to a level of care including medical services provided in a 24-hour medically managed setting.

A.85. Intensive Care Management (ICM): Intensive care management refers to the process of organizing the patient care activities of an individual with significant clinical problems or circumstances which prevent them from effectively utilizing medically necessary care.

A.86. Intensive Care Manager: An independently licensed clinician employed by the Contractor who is responsible for managing and coordinating the care of individuals who are eligible for intensive care management.

A.87. Level of Care (LOC) Guidelines: Guidelines that are used by the Contractor to conduct utilization management and which help to determine whether a service is medically necessary and medically appropriate.

A.88. MLIA Medicaid for Low-Income Adults: A coverage group for adults between the ages of 19 and 64 who do not receive Medicare or SSI. This eligibility group was authorized by the Affordable Care Act and includes clients who were formerly eligible for the state funded State Administered General Assistance (SAGA) program.

A.89. Medicaid: One of the Connecticut Medical Assistance Programs, operated by the Connecticut Department of Social Services under Title XIX of the federal Social Security Act, and related State and Federal rules and regulations.

A.90. Medicaid Management Information System (MMIS): The Department's automated claims processing and information retrieval system certified by CMS. It is organized into several function areas- Recipient (Member), Provider, Claims, Reference, Financial, Buy-In and Internet. Management and Administrative Reporting subsystem (MAR) and Surveillance and Utilization Review subsystem (SUR) are certified as part of the MMIS but are contained in the Data Warehouse.

A.91. Medicaid Program Provider Manuals: Service-specific documents created or issued by the DEPARTMENT to describe policies and procedures applicable to the Medicaid program generally and that service specifically.

A.92. Medical Assistance: For the purposes of this RFP, Medical Assistance will mean all of the healthcare and related programs administered by the Department of Social Services, including but not limited to Medicaid, CHIP, and the Charter Oak Program.

A.93. Medically Necessary or Medical Necessity: Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is

generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

A.94. Member: An individual eligible for coverage under any of the Department's medical assistance programs included in the scope of this RFP and whose medical benefits are managed by the Contractor.

A.95. Money Follows the Person: A Connecticut initiative designed to promote personal independence and achieve fiscal efficiencies. It is funded by CMS and the State of Connecticut as part of a national effort to "rebalance" long-term care systems, according to the individual needs of persons with disabilities of all ages.

A.96. National Committee on Quality Assurance (NCQA): A not-for-profit organization that develops and defines quality and performance measures for managed care, thereby providing an external standard of accountability.

A.97. National Provider Identifier: A standard, unique identifier for health care providers and health plans developed as a component of HIPAA Administrative Simplification. CMS developed the National Plan and Provider Enumeration System to assign these identifiers.

A.98. Network Manager: An employee of the Contractor who supports provider network development by providing profiling analyses and results, developing continuous quality improvement plans, and supporting providers and communities in the execution of the plans.

A.99. Normal Business Hours: The normal business hours for the Contractor will be 9 AM through 7 PM, Monday through Friday except for seven (7) holidays: New Years Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day, the day after Thanksgiving Day, and Christmas Day.

A.100. Operational: Performance by the Contractor of all of the major functions and requirements of this RFP and subsequent contract for all members.

A.101. Outlier Management: Utilization management protocols geared toward client- or provider-based utilization levels that fall below or exceed established thresholds.

A.102. Out-of-Network Provider: A provider that is not enrolled in the Connecticut Medical Assistance Program Provider Network.

A.103. Patient-Centered Medical Home (PCMH): A Person-Centered Medical Home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The provider is required to provide this coordination and is encouraged to improve practice infrastructure in order to qualify as a medical home.

A.104. Peer Advisor: Doctor- level licensed health professionals employed by the Contractor who are qualified, as determined by the medical director, to render a clinical opinion about the medical condition, procedures, and treatment under review.

A.105. Peer Desk Review: A review of available clinical documentation conducted by an appropriate peer advisor when a request for authorization was not approved during the initial clinical review conducted by a care manager.

A.106. Peer Review: A telephonic conversation between the Contractor's peer advisor and a provider requesting authorization when the request does not appear to meet the medical necessity guidelines and either the provider or the peer advisor believes that additional information needs to be presented in order to make an appropriate medical necessity determination. Peer review also includes a review of available clinical documentation.

A.107. Peer Review Organization (PRO): (See Quality Improvement Organization.)

A.108. Performance Review: An on-site review by the Department for the purpose of determining whether and to what extent the Contractor is operating its administrative services in accordance with the terms of this RFP and subsequent contract.

A.109. Post-Stabilization Services: Services that a treating physician views as medically necessary after an emergency medical condition has been stabilized during an emergency department visit.

A.110. Preferred Practice: Designation given by the Department to recommended clinical/intervention practices.

A.111. Presumptive Eligibility: A method of determining temporary Medicaid eligibility for individuals under the age of nineteen (19) and pregnant women, or temporary CHIP eligibility for children. The determination is made by organizations authorized under federal and State law and approved by the Department to make presumptive eligibility determinations. These

organizations are called Qualified Entities or Qualified Providers. Individuals and pregnant women who are given presumptive eligibility become entitled to Medicaid or CHIP benefits on the date the Qualified Entity or Qualified Provider makes the determination.

A.112. Primary Care Provider (PCP): A licensed health care professional, including licensed Obstetrician/Gynecologists, responsible for performing or directly supervising the primary care services of members.

A.113. Primary Care Services: Services provided by health professionals specifically trained in comprehensive first contact and continuing care for persons with any health concern. Primary care includes health promotion, disease prevention, health maintenance counseling, patient education, diagnosis and treatment of acute and chronic illnesses, in a variety of health care settings (e.g. office, inpatient, home, etc.).

A.114. Prior Authorization: Refers to the Contractor's process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by the Contractor as to whether the requested service is medically necessary.

A.115. Procedure Codes: A broad term to identify systematic numeric or alphanumeric designations used by healthcare providers and medical suppliers to report professional services, procedures and supplies. Among the procedure codes used in this document are Healthcare Common Procedure Coding System (HCPCS, which include CPT codes) and Revenue Center Codes (RCCs).

A.116. Professional: A practitioner licensed or certified by the Connecticut Department of Public Health to provide health care services.

A.117. Provider: A person or entity under an agreement with the Department to provide services to members.

A.118. Provider Network: Provider Network means all providers enrolled in the Connecticut Medical Assistance Program Provider Network that serves members.

A.119. Qualified Entity: An entity that is permitted under federal and state law to determine presumptive eligibility for Medicaid.

A.120. Qualified Provider: A medical provider who is eligible for Medicaid payments; provides the type of services provided by outpatient hospitals, rural health clinics, or other physician directed clinics; has been determined by the Department to be capable of making presumptive eligibility determinations; and receives funds under either the federal Public Health Service Act's Migrant Health Center or Community Health Center programs, the Maternal and Child

Health Services block grant programs or Title V of the Indian Health Care Improvement Act.

A.121. Quality Improvement Organization (QIO) or QIO-like entity: An organization designated by CMS as a QIO or QIO-like entity (formerly PRO or PRO-like entity), with which a state can contract to perform medical and utilization review functions required by law.

A.122. Quality Management (QM): The process of reviewing, measuring and continually improving the processes and outcomes of care delivered.

A.123. Random Retrospective Audit: Audits conducted for the purpose of determining a provider's continued qualification as a high performing provider for the purpose of the bypass program.

A.124. Recovery: A process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within the limitations imposed by that condition.

A.125. Registration: The process of notifying the Department or its agent of the initiation of a medical service, to include information regarding the evaluation findings and plan of treatment, which may serve in lieu of authorization if a service is designated by the Department as requiring notification only.

A.126. Requestor: The provider that is requesting authorization of a service on behalf of a member.

A.127. Retroactive Medical Necessity Review: Refers to the Contractor's process for approving payment for covered services after the delivery of the service or initiation of the plan of care based on a determination by the Contractor as to whether the requested service is medically necessary. Such reviews typically apply when a service is rendered to an individual who is retroactively granted eligibility, when the effective date of eligibility spans the date of service and the service requires authorization.

A.128. Retrospective Chart Review: A review of provider's charts to ensure that the provider's chart documentation supports the utilization management practices, for example, that the documentation is consistent with the provider's verbal report and corresponding authorization decision. The charts selected for review may be random or targeted based on information available secondary to the utilization management process.

A.129. Retrospective Utilization Review: A component of utilization management that involves the analysis of historical utilization data and patterns of utilization in order to inform the ongoing development of the utilization management program.

A.130. Revenue Center Codes (RCC): A national coding system used to define specific medical services used by hospitals and certain other providers.

A.131. Standard Report: A report that once developed and approved will be placed into production on a routine basis as defined in the contract.

A.132. State Fiscal Year (SFY): July 1st through June 30th of the following year.

A.133. Subcontract: Any written agreement between the Contractor and a third party that obligates the third party to perform any of the services required to be provided by the Contractor under this RFP and subsequent Contract.

A.134. Subcontractor: A third party that, pursuant to the terms of a written agreement with the Contractor, is obligated to perform any of the services required to be provided by the Contractor under this RFP and subsequent contract.

A.135. Tax identification number (TIN): The federal identification number, either Social Security number or employer identification number, that is used by a provider for tax filing, billing and reporting purposes.

A.136. Third Party: Any individual, entity or program that is or may be liable to pay all or part of the expenditures for covered services for a Member.

A.137. Title XIX: The provisions of 42 United States Code Section 1396 et seq., including any amendments thereto, which established the Medicaid program. (See Medicaid).

A.138. Title XXI: The provisions of 42 U.S.C. § 1397aa et seq., providing funds to enable states to initiate and expand the provision of child health assistance to uninsured, low-income children (see CHIP).

A.139. Transitional Care Management: Transition care management is a person-centered, interdisciplinary process to plan for and facilitate preparation for discharge of members from inpatient acute care and chronic disease hospital care.

A.140. Unique Client Identifier (UCI): A single number or code assigned to each person in a data system and used to individually identify that person.

A.141. Urgent Cases: Illnesses or injuries of a less serious nature than those constituting emergencies but for which treatment is required to prevent a serious deterioration in the individual's health and for which treatment cannot be delayed without imposing undue risk on the individual's' well-being until the individual is able to secure services from his/her regular physician(s).

A.142. Utilization Management (UM): The prospective, retrospective or concurrent assessment of the medical necessity of the allocation of health care resources

A.143. Utilization Management (UM) Protocol: Guidelines approved by the Department and used by the Contractor in performing UM responsibilities.

A.144. Utilization Management (UM) Staff: Contractor's clinicians and care managers.

A.145. Vendor: Any party with which the Contractor has contracted to provide services to support its business, other than the clinical and administrative services that are required under this RFP and subsequent contract.

A.146. Warm transfer: A process that allows the Contractor to transfer the caller directly to the individual who can assist the caller and, when such individual is available, to introduce the call in advance of executing the transfer and remain on the call as a participant. For example, if a member calls the Contractor regarding transportation, it would be expected that the Contractor would contact the appropriate Department transportation broker and transfer the caller directly to the transportation broker.

A.147. Well-Care Visits: Routine physical examinations, immunizations and other preventive services that are not prompted by the presence of any adverse medical symptoms.

A.148. WIC or Women, infant, Children Program: The federal Special Supplemental Food Program for Women, Infants and Children administered by the Department of Public Health, State of Connecticut as defined in Conn. Gen. Stat. § 17b-290.

B. PROGRAM DESCRIPTION

B.1. Summary of the Proposed Initiative

B.1.1. The Department of Social Services is procuring an Administrative Services Organization (ASO) to administer the medical portion of its entire scope of health care programs. The Department's behavioral health and dental health programs are administered by other contractors. The Department's primary objective in contracting with an ASO is to improve quality of care and the care experience for our members, while reducing cost. Secondary goals include fostering change in local service delivery through the provision of performance data and technical assistance to support the emergence of medical homes and integrated care organizations.

B.1.2. Bidders are expected to propose two strategic business plans to achieve substantive improvements in service access, appropriateness and quality while reducing expenditures over the course of the 5-year contract:

B.1.2.1. The first plan must be a FULL SCOPE – OPTION A proposal which is fully responsive to the scope of work;

B.1.2.2. The second plan must be a REDUCED SCOPE – OPTION B in which the bidder proposes reductions in scope to optimize the value of the Contractor's services relative to Departmental goals but reduces the overall cost of the Contract. Reductions might include the elimination of functions, reducing the scope or extent of various functions, or easing proposed timeframes.

B.1.3. The Department may select one or more bidders to carry out the requirements of the contract resulting from this RFP. If more than one bidder is chosen, the scope of work will be divided geographically so that each bidder will be the sole contractor in a geographically defined area. Accordingly, the bidder must submit two bids, the first of which (OPTION A) shall be priced based on full enrollment and the second of which (OPTION B) shall be priced under the assumption that enrollment will be divided among two or more bidders.

B.2. Description of Proposed Program

B.2.1. The Department of Social Services currently manages medical benefits under two arrangements:

B.2.1.1. The benefits for members who qualify for Medicaid on the basis of age or disability status, as well as low-income adults, are managed under a fee-for-service program.

B.2.1.2. The benefits for members who qualify for Medicaid family coverage groups (HUSKY A), Connecticut's CHIP program (HUSKY B), and Connecticut's Charter Oak Health Plan are all managed under fully capitated risk arrangements with three managed care organizations.

B.2.1.3. Behavioral health and dental benefits are administered under administrative services organization arrangements. Pharmacy benefits are administered directly by the Department and HP Enterprise Solutions, the Department's MMIS contractor.

B.2.2. Pursuant to Conn. Gen. Stat. Section 17b-261m, the Department of Social Services is authorized to procure an Administrative Services Organization (ASO) to manage medical services provided to all of the Medical Assistance clients above, effective January 1, 2012.

B.2.3. Under its contract with the Department, the ASO will provide a range of management services including centralized customer call center services, utilization management, care coordination, intensive care management,

quality management, reporting, predictive modeling, health risk assessment, provider profiling and other administrative services.

B.2.4. The ASO will assist Medical Assistance members with referrals and appointment scheduling, including accessing EPSDT services, with access to services administered by the Department's other ASOs (including non-emergency transportation), and will assist members with navigating the health care system. The resultant contract between the Department and the ASO will include financial incentives to encourage the ASO to, at a minimum, meet performance targets set by the Department.

B.2.5. Members will use the Connecticut Medical Assistance Program (CMAP) network, which is the Department's existing fee-for-service network. Claims will be processed through the Department's MMIS claims processing system. The ASO will be required to facilitate monitoring and expansion of the provider network in order to ensure access to necessary medical services.

B.2.6. A person-centered approach to care will be a hallmark of the new delivery system and not just an approach limited to the person-centered medical homes. Person-centered care has its focus on the person and not on the person's disease, illness or condition. In a person- centered system, behaviors and symptoms are understood after first learning about how the person experiences his or her situation. This requires an understanding of the person's life circumstances and preferences, combined with up-to-date evidence-based knowledge about individualized medical treatment.

B.2.7. The following are examples of an approach to person-centered care. The Provider:

B.2.7.1. Uses the person's own experience as point of departure.

B.2.7.2. Strives to understand behaviors and symptoms from the perspective of the person.

B.2.7.3. Tailors care and treatment to each individual.

B.2.7.4. Promotes both empowerment of the person and shared decision making.

B.2.7.5. Involves the person as an active, collaborative partner.

B.2.7.6. Strives to involve the person's social network in his/her care.

B.2.8. Individual recipients of a person-centered approach to care actively participate in decision-making and their feedback is sought to ensure that

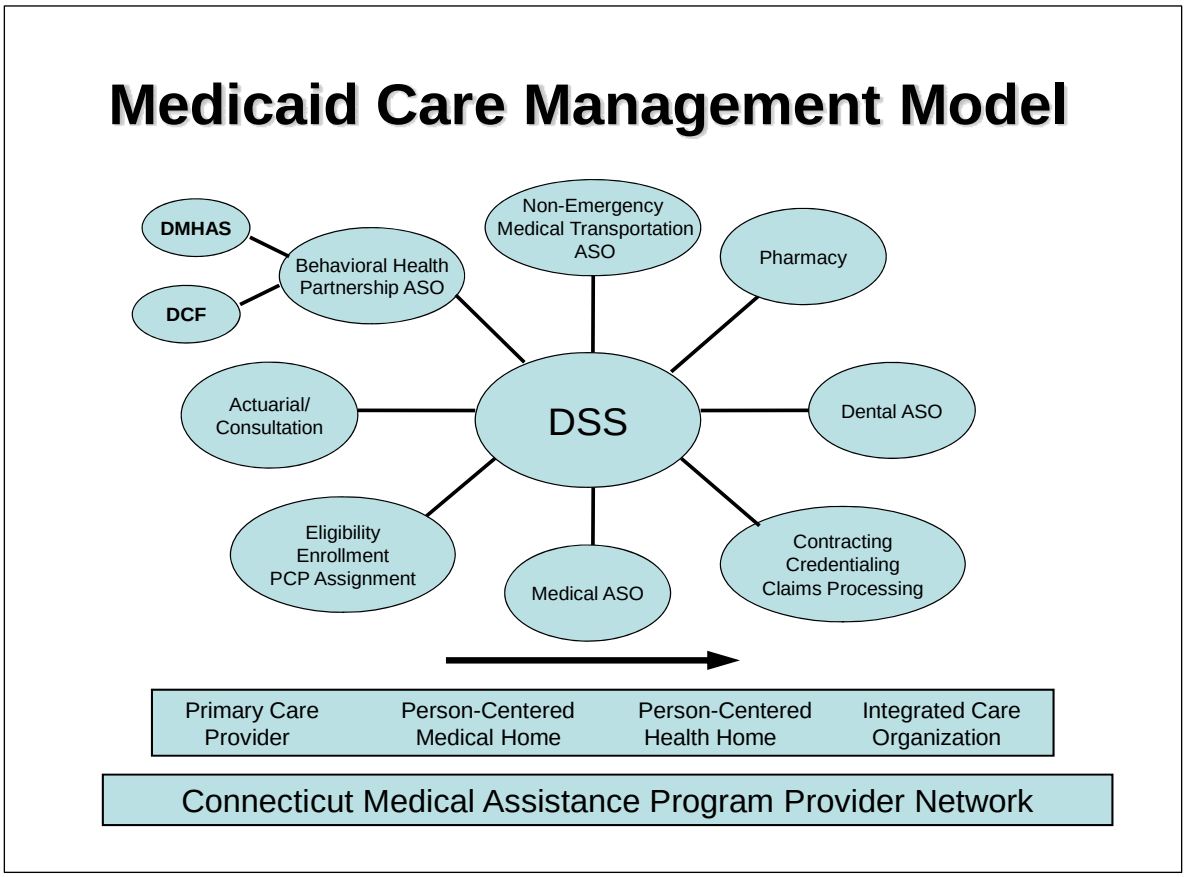
the member's expectations are being met. Individuals and their families (if appropriate) participate in quality improvement activities at the practice level.

B.2.9. Beginning in 2011, the Department will aggressively pursue approaches to health care purchasing designed to promote improvements in service delivery and organization, accountability among local health care systems, in an effort to improve patient outcomes and achieve efficiencies. The Department will begin by supporting the emergence of medical homes for all Medicaid, HUSKY A, HUSKY B, and Charter Oak recipients. Although there are many definitions of medical home, for the Department's purposes, it is essentially a person-centered approach to providing comprehensive primary care that facilitates partnerships between individuals and their providers and, when appropriate, the individual's family and other supports. The medical home also serves as a focal point for information sharing and referral to specialists and sub-specialists, as well as communication, evaluation and interpretation of specialist recommendations. It typically relies on advanced health information systems to support evidence-based care and includes resources to support the coordination of care. The development of medical homes will allow better access to health care, increased satisfaction with the care process, and improved health and health outcomes. It is anticipated that the ASO contract will require the provision of technical assistance in the field and data to support the emergence and ongoing operations of medical homes, health homes, and other service delivery innovations, such as Integrated Care Organizations. Medical homes will be established as early as January 1, 2012.

B.2.10. In addition to aggressively moving to the person-centered medical home model of care, the Department will also begin planning for the submission of a State Plan Amendment to establish health homes, a new opportunity under the Affordable Care Act to improve care for individuals with multiple chronic conditions. Health homes expand on the medical home concept by placing a greater emphasis on: comprehensive care management; disease education, self-management, and health promotion; care transitions including appropriate follow-up from inpatient to other settings; referral to needed community and social support services; use of health information technology to link services; and reliance on a team of health care and support professionals. Only a subset of medical homes are expected to qualify as health homes. No date has been set for the implementation of the health home initiative.

B.2.11. Finally, The Department has applied for federal funding to support full integration of care for individuals who are eligible for both Medicare and Medicaid (i.e., dual eligibles). The federal Centers for Medicare and Medicaid Services will be awarding funds to 15 states. If awarded, Connecticut's demonstration will establish local Integrated Care Organizations (ICOs) with accountability for the delivery and coordination of

primary/preventive, acute, and behavioral health services integrated with long-term supports and services and medication management for dual eligibles. The ICO model features partnerships among multiple provider types and is facilitated by health information technology and the measurement of quality, outcomes and cost. In order to promote value, the state will align financial incentives to performance – the enhancement of quality of care, the care experience and health outcomes at a lower overall cost. Regardless of whether Connecticut is selected as one of the states to receive this additional federal support, transitioning clients to an ASO will provide needed care management and improved patient care.



B.2.12. The restructuring of the health care delivery system must not impact the ability of clients to receive necessary medical care. Instead the system must provide for improved care management and outcomes, while ensuring that the state's limited resources are spent in a cost effective and efficient manner.

B.3. Overview of the Department of Social Services

B.3.1. The Department provides a broad range of services to older adults, persons with disabilities, families, persons who need assistance in maintaining or achieving their full potential for self-direction, self-reliance, and independent living, as well as persons unable to afford or ineligible for commercial health insurance coverage. It administers more than ninety legislatively authorized programs and about one-third of the State budget. By statute, it is the State agency responsible for administering human service programs sponsored by Federal legislation including the Rehabilitation Act; the Food, Conservation and Energy Act of 2008; the Older Americans Act and the Social Security Act. The Department is also designated as a public housing agency for administering the Section 8 Program under the Federal Housing Act.

B.3.2. The Commissioner of Social Services heads the Department and there is currently one Deputy Commissioner. Three Regional Administrators are responsible for each of the Department's three geographic service regions. By statute, there is a Statewide Advisory Council to the Commissioner of Social Services and each geographic service region must have a Regional Advisory Council.

B.3.3. The Department administers most of its programs at offices located throughout the State. Within the Department, the Bureau of Rehabilitation Services provides vocational rehabilitation services for eligible persons with physical and mental disabilities throughout the State. For the other programs, services are available at offices located in the three geographic service regions, with central office support located in Hartford. In addition, many services funded by the Department are available through community-based agencies. The Department has out-stationed employees at participating hospitals and nursing facilities to expedite Medicaid applications and funds Healthy Start sites, which can accept applications for Medicaid for pregnant women and young children. Many of the services provided by the Department are available via mail or telephone.

B.3.4. There are four entities attached to the Department for administrative purposes only. They are the Commission on the Deaf and Hearing Impaired, the Board of Education and Services for the Blind, the Child Day Care Council.

B.3.5. The Connecticut Medicaid Program is operated by The Department under Title XIX of the Social Security Act. The Department is the designated "single state agency" for Connecticut's Medicaid program. Currently, Medicaid clients in TANF and other family-related eligibility groups receive services through managed care organizations under the HUSKY A program. The MCOs are paid a per member, per month capitation amount. The MCOs coordinate all medical services for the HUSKY A population. Dental and behavioral health benefits are administered by separate ASOs and the

B.3.6. The Department also operates the HUSKY B program as a separate (non-Medicaid) program under Title XXI of the Social Security Act (Children's Health Insurance Program). HUSKY B provides health coverage to uninsured children who are U.S. citizens or qualified non-citizens under the age of 19 in families with income below 300% of the federal poverty level. HUSKY B requires small co-payments and coinsurance for non-preventive services and also requires a monthly premium depending on income and family size. HUSKY B benefits also include the HUSKY Plus Physical benefit package for Children and Youth with Special Health Care Needs. HUSKY Plus provides supplemental medical coverage for eligible children with intensive physical health care needs with subsidized coverage in HUSKY B.

B.3.7. The Department also administers a state-funded medical assistance program, the Charter Oak Health Plan. Implemented in 2008, Charter Oak was developed to provide health benefit coverage to Connecticut adults ineligible or unable to afford commercial health insurance. Currently, this program is administered in partnership with the three HUSKY managed care organizations. The benefits are structured similar to commercial benefits, with monthly premiums charged to members to provide covered medical services, some of which are available after meeting annual deductible payments. There are also annual benefit cost caps for total benefit, pharmacy and durable medical equipment utilization, as well as a lifetime benefit limit. The responsibilities for management of the Charter Oak Program will be transitioned to the ASO selected through this procurement.

B.3.8. The Department also administers a fee-for-service program that includes approximately 90,000 single eligibles (primarily clients in the Aged, Blind and Disabled eligibility categories and MLIA) and approximately 70,000 Medicaid/Medicare dual eligibles. Single eligibles receive a full range of covered hospital, physician, clinic, home health, pharmacy, dental and community services. Dual eligibles receive their hospital, physician, pharmacy, and other medical services through Medicare. Medicare also pays for short term home health services and short term nursing home stays. Medicaid covers any Medicare cost sharing requirements, up to the Medicaid allowed amount, and also covers benefits that Medicare does not cover such as longer term home health services, some medical equipment, and other services.

B.3.9. Under the Connecticut Behavioral Health Partnership (CT BHP), the Department administers behavioral health services through a contract with an administrative services organization (ASO). The Departments of Children and Families and Mental Health and Addiction Services are also

B.3.10. The Connecticut Dental Health Partnership (CTDHP) is the statewide dental plan managed by the Department for clients enrolled in its Medical Assistance programs, with the exception of Charter Oak. The CTDHP contracts with an ASO to oversee the day to day administrative, utilization and service delivery processes. The CTDHP partners with oral health professional organizations, state agencies, advocacy groups and providers to improve the program, including collaboration on special outreach initiatives focusing on pregnant individuals, individuals who underutilize services and individuals with special health care needs.

B.3.11. The Department administers the pharmacy benefit program for individuals enrolled in the Department's Medical Assistance Programs (Medicaid, HUSKY B, Charter Oak, CADAP and ConnPACE). The Department's Medical Care Operations unit provides contract management and oversight to HP relative to the Drug Rebate Program, a Nursing Home Drug Return Program, Prospective & Retrospective Drug Utilization Review/DUR Board, administration of a Preferred Drug List/P&T Committee, Prior Authorization, a Nursing Home Drug Return Program, Pharmacy Lock-in Program, and interfaces with Medicare Part D.

B.3.12. Adult single or dual eligibles may be enrolled in any of the Department's home and community based waiver programs which currently include the following:

B.3.12.1. Developmental Disabilities - Comprehensive Waiver

B.3.12.2. Developmental Disabilities – Individual and Family Support

B.3.12.3. Mental Health Waiver

B.3.12.4. Acquired Brain Injury Waiver

B.3.12.5. Connecticut Home Care Program for Elders

B.3.12.6. Personal Care Assistance Waiver

B.3.12.7. Katie Beckett Model Waiver

B.3.12.8. Assisted Living Waiver

B.3.13. The two Development Disabilities waivers are administered by the Department of Developmental Services. The Mental Health Waiver is administered by the Department of Mental Health and Addiction Services. Several additional waivers will be added in the coming year including a DDS Supports Waiver, three Autism Waivers, and an HIV Waiver.

B.3.14. In addition to these waiver programs, the Department administers the Money Follows the Person (MFP) program, which provides home and community based services to individuals who have resided in an institutional setting (typically a nursing facility) for more than 3 months. Individuals participate in MFP for one year before transferring to one of the above waiver programs.

B.4. Populations Covered

B.4.1. The intended populations to be served by the ASO under the resultant contract are all Medical Assistance clients. This includes: Medicaid clients who are Aged, Blind and Disabled (ABD), Medicaid Low Income Adults (MLIA), or adults and children who qualify for family coverage (HUSKY A); CHIP (HUSKY B); and the Charter Oak Health Plan. Medicare and Medicaid "dual eligible" clients will also be served by the ASO. In total, if a single contract is awarded, the new ASO will be responsible for administration of the care for nearly 600,000 individuals.

B.5. The Role of the Administrative Services Organization

B.5.1. Overview: The Contractor as the ASO will serve as the primary vehicle for organizing and integrating clinical management processes across payer streams. The ASO's main function will be to support access to primary and preventive care and specialty care on both an inpatient and outpatient basis, maintain the delivery of high quality and high value services and prevent unnecessary utilization of care, especially in inappropriate settings. The ASO will be expected to enhance communication and collaboration within the health care delivery system, assess provider network adequacy on an ongoing basis, and improve the overall delivery system by working with the Department to recruit and retain healthcare providers. The ASO will also be expected to support and assist the Department in its efforts to ensure that all clients have a medical home appropriate to their health care needs, by supporting the Department's efforts to build upon existing initiatives in this area towards a comprehensive, regionalized health home or integrated care organization model.

B.5.2. Primary Care Provider Assignment and PCMH/HH Attribution: The ASO will be responsible for establishing a usual source of primary care for all Members. Initially, every individual will be asked to choose a primary care provider (PCP). Those Members who do not choose a PCP will be assigned one by the ASO based on where the individual has gone for care in the past

and existing provider capacity. As a network of Patient-Center Medical Homes and Health Homes (PCMH/HH providers) emerges, the ASO will also be responsible for administering the attribution (otherwise known as assignment) of individuals to a PCMH/HH. This attribution may be in addition to specific assignment to a PCP within the PCMH/HH. It is anticipated that members will have the opportunity to opt out of PCMH/HH attribution. This remains a point of discussion between the Department and Connecticut's advocacy community.

B.5.3. Utilization Management: The ASO will be required to provide prospective, concurrent and retrospective utilization management (UM) services for Members. Either registration or prior authorization may be used. Registration is reserved primarily for less complex or costly procedures or service areas. Prior authorization and continued care review are reserved for services with higher risk of adverse member health outcome, less likelihood of clinical benefit, or greater potential for inappropriate use. The quality of services provided is monitored and managed and frequent users or potential frequent users of services are identified through prospective, concurrent and retrospective review processes. The UM Program supports providers in delivering clinically necessary and effective care with minimal administrative barriers. The criteria to determine care to be provided shall be the Department's definition of medically necessary services, as required by Connecticut General Statutes Section 17b-259b. The ASO may purchase, license or develop other guidelines or criteria to assist in utilization decisions, but the legal definition of "medical necessity" must always be determinative.

B.5.4. Intensive Care Management - Many members will receive Intensive Care Management (ICM) services when they meet criteria established by the ASO and the Department. ICM refers to specialized care management techniques when a Member has significant health care needs that are not being adequately or effectively addressed. Criteria for ICM may include, but are not limited to, members with an unstable chronic condition or behavioral health condition, more than one chronic condition with or without co-occurring behavioral health conditions; developmental delays; acute conditions at risk of resulting in adverse long term outcomes, such as some pregnancies or severe trauma; or chaotic social or living circumstances.

B.5.5. The ASO will facilitate the convening of a multi-disciplinary team to create a personal plan of care when clinically necessary. The process of development of an ICM plan of care will begin with identification of key clinicians and care givers necessary to the individual's care, as well as the individual member and/or their designated family members or parent(s). For those individuals who require ICM services, the Department requires the ASO to develop a written ICM plan. Existing care plans will be reviewed with Providers to ensure that they reflect the Member's individual needs and

adequately address their complex medical issues. Multi-disciplinary team meetings will most frequently be virtual in order to accommodate busy clinicians' schedules.

B.5.6. Only a small percentage of members will need ASO-directed ICM services. The ASO's identification of Members who will benefit from ICM due to their chronic conditions will be key to achieving successful outcomes. Equally important is the timely identification of Members whose clinical conditions or social circumstances place them at risk of eventually requiring ICM services. Early intervention for Members at risk may avoid or minimize their eventual need for ICM services.

B.5.7. The ASO will provide ICM at the ASO's Connecticut service center. However, regional deployment of Intensive Care Managers in the field may help build local collaborative relationships and improve effectiveness. As the ASO and the Department recruit and certify PCMHs and HHs, the ASO will have less of a role in coordinating care for individuals assigned to the PCMH practices. In many cases, it is expected that the ASO will identify high risk individuals and provide linkages to the PCMH. PCMH practices that meet the special requirements for serving as a Health Home will be expected to provide all necessary ICM (or the equivalent) for members attributed to them. Here as well, the ASO will be expected to identify high risk members and link these members to their ICM counterparts employed by the Health Home.

B.5.8. Although the Department envisions a migration of care coordination and ICM functions to local PCMH/HH practices, clinics and service delivery systems, there may be an ongoing role for the ASO with respect to these functions. These ASO functions will continue to be necessary for individuals who are not assigned to a PCMH/HH. In addition, it is possible that the ASO could establish local ICM service hubs that support members by linking them to small group practices too small to establish dedicated resources on site.

B.5.9. By providing UM services and ICM services, the ASO will have a significant impact on the quality of clinical care and clinical care decisions. In doing so, it must make every effort to support collaborative clinical care decision-making at the local level, inform and support care-planning processes, support the meaningful participation of families and consumers in directing their own care, and enhance, rather than impede, member access to medically necessary, high quality and high value health services.

B.5.10. The ASO's UM and ICM processes must support effective system management, easy access to appropriate services, and the development and maintenance of high quality services. In order to achieve improvements in care, the management techniques and principles utilized by the ASO must support the following "Key Aspects" of quality care:

B.5.11. Coordination and Continuity of Care - Care must be provided in a fashion that is both well coordinated and easy for consumers to utilize, with better access to information and services through a one-stop source for assistance.

B.5.12. Emphasis on Preventive Care and Early Intervention: The most efficacious and cost-effective care of any illness is to prevent it from ever occurring. If illness does develop, early detection and intervention early in the course of disease is essential to prevent development of chronic illness or the complications of chronic disease.

B.5.13. Value-added Services: Services must maximize the quality of service and patient outcomes, emphasizing informed consumer choice and the ability of the system to meet the needs of the members. Creative person-centered planning approaches should be promoted and supported, and should result in shared decision making.

B.5.14. Greater Accountability: The service system must keep families and consumers engaged to seek the input necessary to improve its performance as measured by consumer satisfaction, quality of life, and positive health outcomes.

B.5.15. Cultural Competency: The unique linguistic and cultural needs of the client and family need to be recognized and respected as individual services are identified and coordinated. The unique cultural diversity within the state must be recognized and respected as the system increases its service and system scope.

B.5.16. Quality Management: The ASO will be expected to conduct ongoing quality management activities and performance improvement initiatives. The quality management activities include monitoring access and quality issues and proposing regional or statewide initiatives that improve performance. In addition, the ASO will be expected to undertake a core set of access and quality initiatives in addition to any initiatives that the ASO may propose to undertake. These initiatives include improving access to EPSDT and adult well visits; improving screening for childhood developmental delays; behavioral health conditions including adult and perinatal depression; breast, cervical and colon cancers; appropriate use of preventive services such as controller medications for asthma; monitoring for eye, heart, kidney and foot disease in patients with diabetes; utilization of care in appropriate settings; improving member satisfaction with the service delivery system; and working with hospitals to minimize unnecessary emergency department visits and inpatient care.

B.5.17. Data Analytics, Reporting and Performance Measurement: Perhaps the most important ongoing role for the ASO is the use of data to inform policy, direct resources, and monitor statewide and local system

performance. The Department has proposed in Exhibit E an initial statewide measurement set to guide policy and direct management resources. This Exhibit will be amended during contract negotiations to reflect the reporting proposed by the Contractor and agreed to by the Department.

B.5.18. In addition, the ASO will be expected to gather and report information necessary to assess and compare performance at the local level. The focus of these performance profiling activities will include local service delivery systems or geographic regions and/or PCMH and HH providers as they relate to the quality of services provided to their attributed members. One essential component of quality service in a person-centered system is member satisfaction; therefore performance profiling activities will include opportunities for members to evaluate providers and the service delivery system. As these provider systems evolve and affiliate as integrated care organizations or Accountable Care Organizations, the ASO's reporting will be expected to evolve to encompass the performance of these new, larger provider consortia. Performance measurement will support the payment of bonus or other financial incentive payments to providers and will need to be in place at the earliest stages of this initiative. The Department is interested in the bidder's proposed performance measures for monitoring local provider and system performance.

SECTION II: OVERVIEW OF PROCUREMENT PROCESS

A. Issuing Office and Contract Administration

A.1. The Department is issuing this Request for Proposals (RFP), through the Department's Office of Contract Administration on behalf of the Department. This office is the only contact in the State of Connecticut (State) for this competitive bidding process.

A.2. The integrity of the procurement process is based, in part, on ensuring that all potential and intended bidders be afforded the same information and opportunities regarding the terms of the procurement. Therefore, it is incumbent upon the Issuing Office to monitor, control and release information pertaining to this procurement. Potential and intended bidders are advised that they must refrain from contacting any other office within the State of Connecticut or any other state employee with questions or comments related to this procurement. Potential and intended bidders who contact others within the State of Connecticut with questions or issues pertaining to this procurement may risk disqualification from consideration. Decisions regarding such disqualification will be made by the Department's Contract Administrator, within the Issuing Office, after consultation with the Office of the Commissioner.

A.3. The Contract Administrator and the contact information for the Issuing Office is as follows:

Kathleen M. Brennan
Contract Administration
Department of Social Services
25 Sigourney Street
Hartford, CT 06106
Phone: (860) 424-5693 - Fax: (860) 424-4953
Email: kathleen.brennan@ct.gov

A.4. All questions, comments, proposals and other communications with the Issuing Office regarding this RFP must be submitted in writing in sealed envelopes or sealed boxes clearly identifying, "MEDICAL ASO RFP". Any material received that does not so indicate its RFP-related contents will be opened as general mail.

B. Procurement Schedule

Milestones modify dates	Ending Dates
RFP Released	4/06/2011
Bidders Conference	4/19/2011
Deadline for Letter of Intent 3:00 PM Local Time	4/21/2011
Deadline for Written Questions 3:00 PM Local Time	4/28/2011
Responses to Questions (tentative)	5/5/2011
Proposals Due by 3:00 PM Local Time	5/26/2011
Successful Bidder Announced	7/1/2011
Contract Negotiations Begin	7/1/2011
Execute Contract	8/1/2011
Operational Program Begins	1/1/2012

C. Bidders' Conference

C.1. The Department will sponsor an optional Bidders' Conference with regard to this RFP on Tuesday, April 19, 2011 at 9:30 AM Local Time in Mezzanine Conference Room 2A at the State of Connecticut Department of Social Services Central Office located at 25 Sigourney Street, Hartford, CT.

C.2. To ensure the availability of adequate space for all interested parties, organizations will be limited to NO MORE than two (2) attendees. For building access and security purposes organizations and individuals planning on attending the Bidders' Conference are required to submit to the Issuing Office a list of planned attendees no later than 9:00 AM Local Time on Tuesday, April 19, 2011 The list of attendees may be submitted via e-mail or facsimile. It is the responsibility of the submitting party to verify receipt by the Issuing Office.

Identification will be checked and access to the Bidders' Conference will be granted only to those individuals on the security list provided by the Department to building security. The Department encourages bidders to submit questions in advance of the conference. Questions submitted in advance will allow staff to research issues in preparation for the conference.

D. Bidders' Questions

D.1. In addition to questions raised at the Bidders' Conference, the Department will accept written questions and requests for clarification pertaining to this procurement if submitted to and received by the Issuing Office by **3:00 pm on Thursday, April 28, 2011.**

D.2. Written questions and requests for clarification may be sent via email or facsimile to meet this deadline. The Department will only respond to those questions and requests submitted and received by the Issuing Office in writing by the stated deadline. Submit questions and requests for clarification to the Issuing Office directed to the attention of Kathleen M. Brennan by facsimile (860-424-4953) or email (Kathleen.Brennan@ct.gov). The Issuing Office will only respond to those questions raised at the Bidders' Conference and those written questions submitted in accordance with the stated criteria and by the stated deadline. Official responses to all questions will be posted in an amendment to this RFP in the form of an addendum to this RFP, posted on the Department's website at www.ct.gov/dss and the State Procurement/Contracting Portal http://das.ct.gov/cr1.aspx?page=12. The tentative posting date for the addendum is Thursday, May 5, 2011.

D.3. It is solely the Bidder's responsibility to verify the Issuing Office's receipt of written questions and to access the Department's website or the State Procurement/ Contracting Portal to obtain any and all addendums or official announcements pertaining to this RFP. A responsive proposal must include a signed acknowledgment of the receipt of each the addendums to this RFP that are posted to the Charter Oak page on the Department's website or the State Contracting Portal prior to the Proposal submission date.

E. MANDATORY Letter of Intent (LOI)

E.1. Interested Bidders must submit a MANDATORY Letter of Intent to the Issuing Office to advise the Department of their intention to present a proposal in response to this RFP. The Letter of Intent MUST be received by the Issuing Office by 3:00 PM Local Time, Thursday, April 21, 2011.

E.2. The LOI may be faxed or emailed to the Issuing Office. While the Letter of Intent is non binding, an interested bidder MUST submit a Letter of Intent before the date and time set forth herein in order for the Bidders proposal to be reviewed and evaluated. The LOI must include the following information:

E.2.1. the name, telephone number, fax number, and email address of the bidder's contact person for matters related to this procurement; and

E.2.2. A statement certifying that the bidder's proposal shall address the bidders' ability to perform the stated ASO services for all Medical Assistance clients on a statewide basis.

E.3. A LOI that fails to include the required information and certifications will be considered as unresponsive and not accepted. It is the bidders' responsibility to confirm the Issuing Office's receipt of a LOI.

E.4. Potential bidders who elect not to submit a proposal are requested to submit a "No Bid" letter.

F. Procurement Reference Library - The Department will establish a procurement reference library at www.ct.gov/dss for the bidders responding to this RFP. We expect that the library will be available by April 11, 2011.

G. Evaluation and Selection -It is the intent of the Department to conduct a comprehensive, fair and impartial evaluation of proposals received in response to this competitive procurement. Only proposals found to be responsive to the RFP will be evaluated and scored. A responsive proposal must comply with all instructions listed in this RFP, including the general consideration requirements.

H. Contract Execution: The contract developed as a result of this RFP is subject to State contracting procedures for executing a contract which include approval by the Connecticut Office of the Attorney General. Contracts become executed upon the signature of the Attorney General and no financial commitments can be made until and unless the contracts have been approved by the Attorney General. The Attorney General reviews the contract only after the Commissioner and the Contractor have agreed to the provisions.

I. Acceptance of Proposal Content

I.1. If acquisition action ensues, the contents of this RFP and the proposal of the successful bidder will form the basis of contractual obligations in the final contract.

I.2. The resulting contract will be a contract between the successful bidder and the Department. Section I of the contract will contain the description of services to be provided including agreed upon outcomes and measures. Section II of the contract will contain the cost and schedule of payment. Section III of the contract includes the Standard Mandatory Terms and Conditions that have been approved by the Office of the Attorney General and the Office of Policy and Management for all state contracts (Appendix E).

I.3. The Bidder's proposal must include a Statement of Acceptance (Appendix A) without qualification of all terms and conditions as stated within this RFP and the Mandatory Terms and Conditions (Appendix E). The bidder may, however, suggest alternative language to provisions in the Mandatory Terms and Conditions. The Department may, after consultation with the Office of the Attorney General and the Office of Policy and Management, agree to incorporate the alternate language in any resultant contract; however the Department's decision is final. Any proposal that fails to comply in any way with this requirement may be disqualified as non-responsive. The Department is solely responsible for rendering decisions in matters of interpretation on all terms and conditions.

J. Bidder Debriefing

J.1. The State will notify all bidders of any award issued as a result of this RFP. Unsuccessful bidders may, within thirty (30) days of the signing of the resultant contract(s), request a meeting for debriefing and discussion of their proposal by contacting the Contract Administrator in writing at the address previously given.

J.2. Debriefing will not include any comparisons of unsuccessful proposals with other proposals.

K. Disposition of Proposals - Rights Reserved

K.1. Upon determination that its best interests would be served, the Department shall have the right to the following:

K.1.1. Cancellation: Cancel this procurement at any time prior to contract award.

K.1.2. Amend procurement: Amend this procurement at any time prior to contract award.

K.1.3. Refuse to accept: Refuse to accept, or return accepted proposals that do not comply with procurement requirements.

K.1.4. Incomplete business proposal: Reject any proposal in which the Business proposal is incomplete or in which there are significant inconsistencies or inaccuracies. The State reserves the right to reject all proposals.

K.1.5. Prior contract default: Reject the proposal of any bidder in default of any prior contract or for misrepresentation of material presented.

K.1.6. Proposals received after due date: Reject any bidder's response that is received after the deadline.

K.1.7. Written clarification: Require bidders, at their own expense, to submit written clarification of proposals in a manner or format that the Department may require.

K.1.8. Oral clarification: Require bidders, at their own expense, to make oral presentations at a time selected and in a place provided by the Department. The Department may invite bidders, but not necessarily all, to make an oral presentation to assist the Department in its determination of award. The Department further reserves the right to limit the number of bidders invited to make such a presentation. The oral presentation shall only be permitted for purpose of proposal clarification and not to allow changes to be made to the proposal.

K.1.9. On-site visits: Make on-site visits to the operational facilities of bidders to further evaluate the bidder's capacity to perform the duties required in this RFP.

K.1.10. No proposal changes: Allow no additions or changes to the original proposal after the due date specified herein, except as may be authorized by the Department.

K.1.11. Property of the State: Own all proposals submitted in response to this procurement upon receipt by the Department.

K.1.12. Separate service negotiation: Negotiate separately any service in any manner necessary to serve the best interest of the State.

K.1.13. All or any portion: Contract for all or any portion of the scope of work or tasks contained within this RFP.

K.1.14. One or more bidders: Contract with one or more bidders who choose to submit proposals.

K.1.15. Proposal most advantageous: Consider cost and all factors in determining the most advantageous proposal for the Department when awarding bidders the right to negotiate for contracts.

K.1.16. Technical defects: Waive technical defects, irregularities and omissions, if in its judgment the best interests of the Department will be served.

K.1.17. Privileged and confidential communication: Share the contents of any proposal with any of its designees for purposes of evaluating proposals to make an award. The contents of all meetings, including the first, second and any subsequent meetings and all communications in the course of negotiating and arriving at the terms of the Contract shall be privileged and confidential.

K.1.18. Best and Final Offers: Seek Best and Final Offers (BFO) on price from Bidders upon review of the scored criteria. In addition, the Department reserves the right to set parameters on any BFOs it receives.

K.1.19. Unacceptable proposals: Reopen the bidding process if the Department determines that all proposals are unacceptable.

K.1.20. Litigation Review: Examine proceedings, documents, and other material related to legal action taken against the bidder for work performed in other contracts and utilize such information in award decisions.

L. Electronic Copy of Proposal -One exact electronic copy of the entire proposal in a non-PDF format must be submitted with the original. Those required documents that cannot be converted into electronic format may be excluded from the electronic copy.

M. Proposal Preparation Expenses - The State of Connecticut and the Department assume no liability for payment of expenses incurred by bidders in preparing and submitting proposals in response to this procurement.

N. Response Date and Time - The Issuing Office must receive proposals no later than 3:00 p.m. local time on Thursday, May 26, 2011. The Department will not consider a postmark date as the basis for meeting any submission deadline. Bidders should not interpret or otherwise construe receipt of a proposal after the closing date and time as stated herein as acceptance of the proposal, since the actual receipt of the document is a clerical function. The Department suggests the bidder use certified or registered mail to deliver the proposal when the bidder is not able to deliver the proposal by courier or in person. Bidders that are hand-delivering proposals will not be granted access to the building without photo identification and should allow extra time for security procedures. Bidders must address all RFP communications to the Issuing Office.

O. Bidder Assurances - By submission of a proposal and through assurances given in its transmittal letter, the bidder certifies that in connection with this procurement the following requirements have been met:

O.1. Independent Price Determination

O.1.1. Costs: The costs proposed have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such process with any other organization or with any competitor;

O.1.2. Disclosure: Unless otherwise required by law, the costs quoted have not been knowingly disclosed by the bidder on a prior basis directly or indirectly to any other organization or to any competitor;

O.1.3. Competition: No attempt has been made or will be made by the bidder to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition;

O.1.4. Prior Knowledge: The bidder had no prior knowledge of the RFP contents prior to actual receipt of the RFP and had no part in the RFP development; and

O.1.5. Offer of Gratuities: The bidder certifies that no elected or appointed official or employee of the State of Connecticut has or will benefit financially or materially from this procurement. Any contract arising from this procurement may be terminated by the State if it is determined that gratuities of any kind were either offered to or received by any of the aforementioned officials or employees from the Contractor, the contractor's agent or the contractor's employee(s).

O.2. Valid and Binding Offer: The proposal represents a valid and binding offer to provide services in accordance with the terms and provisions described in this RFP and any amendments or attachments hereto.

O.3. Press Releases: The bidder agrees to obtain prior written consent and approval from the Department for press releases that relate in any manner to this RFP or any resulting contract.

O.4. Good Faith Negotiations: The bidder assures the Department, that if selected, it will engage in good faith negotiations to execute a contract by Monday, August 1, 2011 and implement and operate a fully operational system on January 1, 2012 and thereafter.

O.5. Evidence of Qualified Entity: The bidder assures the Department through its legal counsel that it is qualified to conduct business in Connecticut and is not prohibited by its articles of incorporation, bylaws, or the law under which it is incorporated from performing the services required under any resultant contract.

O.6. Restrictions on Communications with Department staff: The bidder agrees that from the date of release of this RFP until the Department makes an award, that it shall not communicate with Department staff on matters relating to this RFP except as provided herein through the Issuing Office. Any other communication concerning this RFP with any of the Department's staff may, at the discretion of the Department, result in disqualification of that bidder's proposal.

O.7. Real or Perceived Conflicts of Interest:

O.7.1. The bidder assures the Department that the company, its principals and staff will avoid any and all real or perceived conflicts of interest with health care providers.

O.7.2. This assurance shall include, but not be limited to an assurance that the organization's principals and staff will have no relationships with health care providers during the term of the contract that could or do conflict with the goals and intent of this project.

O.7.3. A conflict for the organization and staff person would arise when the organization and/or an individual staff person would benefit materially from a relationship with a provider, including but not limited to:

O.7.3.1. when the staff person provides information on behalf of a provider company to the bidder and resulting Contractor and benefits materially from that information sharing;

O.7.3.2. when a staff person or his/her agency/firm has agreed to be a subcontractor for services resulting from any resultant contract;

O.7.3.3. when a staff person serves on the Board of Directors of a provider company.

O.8. Discovery of a Conflict of Interest: The bidder assures the Department that should the bidder (if selected as the resultant Contractor) become aware of an existing, potential or perceived conflict that may compromise its objective provision of services under the resultant contract, the bidder shall immediately disclose this situation to the Department's Contract Administrator. The Contract Administrator will determine the necessary remedy.

O.9. HIPAA Compliance: By submission of a proposal and through assurances given in its Transmittal Letter, the bidder certifies that in connection with this procurement the bidder is compliant or will be compliant as a business associate with the following parts of the Health Insurance Portability and Accountability Act (HIPAA) pursuant to CFR 45 Part 160 and 164. Privacy and Transaction Code Sets.

O.9.1. Note Well: Any proposal that fails to indicate the bidder's compliance as a Business Associate as described above may be disqualified as non-responsive. The Department is solely responsible for rendering decisions in matters of interpretation on all terms and conditions. If the bidder has stated the organization is not currently HIPAA compliant as a Business Associate, the Contractor shall provide a plan demonstrating that the Contractor will be HIPAA compliant with the Privacy and Transaction Code Sets by the date of the Implementation Review, projected for January 1, 2012. The bidder shall provide the plan as fully described in Section V, subsection S: Security and Confidentiality in this RFP.

P. Incurring Costs: The Department is not liable for any cost incurred by the bidder prior to the effective date of a contract.

Q. Freedom of Information:

Q.1. Due regard will be given to the protection of proprietary information contained in all proposals received; however, bidders should be aware that all materials associated with this procurement are subject to the terms of the Freedom of

Information Act, and the Privacy Act and all rules, regulations and interpretations resulting therefrom.

Q.2. Bidder must provide convincing explanation and rationale sufficient to justify each exception from release consistent with Section 1-210 of the Connecticut General Statutes to claim proprietary exemption. It will not be sufficient for bidders to merely state generally that the proposal is proprietary in nature and therefore not subject to release to third parties to claim an exemption. Price and cost alone do not meet exemption requirements.

Q.3. Those particular pages or sections that a bidder believes to be proprietary must be specifically identified as such. The rationale and explanation must be stated in terms of the prospective harm to the competitive position of the bidder that would result if the identified material were to be released and the reasons why the materials are legally exempt from release pursuant to the above cited statute. In any case, the narrative portion of the proposal may not be exempt from release.

Q.4. Between the bidder and the State, the final administrative authority to release or exempt any or all material so identified rests with the State.

R. Declaration of Proprietary Information

R.1. The State of Connecticut shall own all proposals submitted in response to this RFP. Bidders responding to this RFP may declare proprietary components of their proposals. However, such declarations must comply with the Freedom of Information Act (FOIA).

R.2. Bidders making proprietary declarations must clearly identify those sentences or subsections with rationale that complies with FOIA. The State will not accept blanket declarations.

R.3. The Proprietary Declaration should be located immediately following the Table of Contents. Bidders are advised that all proposals submitted in response to this RFP are subject to the FOIA and applicable Connecticut Statutes. A bidder may claim proprietary exemption; however, any decision to release information subject to a FOIA request shall remain with the State.

SECTION III: PROPOSAL FORMAT REQUIREMENTS

A. General Requirements

A.1. Bidders must submit proposals that follow the requirements of this RFP including the requirements of form and format that have been established in order to facilitate the Department's evaluation process. The proposal format requirements are listed in this section below and the content requirements are listed in Section IV.

A.2. The bidder must respond to each content requirement that begins with "The bidder shall" and those responses must reference the RFP request citation. Where the bidder's response would differ by coverage area, the bidder must clearly distinguish the response by coverage area.

A.3. A response template will be available at the Department's website by April, 7 2011.

B. Bidder's Proposal

B.1. Bidder's Proposal - Section One: A separate section labeled "Section One – Transmittal and Assurances Section" must contain each of the transmittal requirements stated in this RFP.

B.2. Bidder's Proposal – Section Two: A separate section labeled "Section Two – Scope of Work Requirements" must contain the bidder's specific responses to each "The Bidder Shall..." statement in Section Two – Scope of Work Requirements.

B.2.1. The bidder's response will generally be in the form of proposals, plans, methodologies, and/or descriptions of various bidder activities that would demonstrate the bidder's understanding of and ability to perform the resultant contractor's performance requirement.

B.2.2. Section Two of the bidder's proposal must present the bidder's understanding of the project, including how the bidder proposes to perform the tasks, identify problems and solve them without a mere re-writing of the RFP requirements. A responsive proposal shall address each task requirement separately and where appropriate the bidder must address different approaches, plans or methodologies for the three categories of clients.

B.3. Bidder's Proposal – Section Three: A separate section labeled "Section Three – Organization, Project Management, Key Personnel" must contain the bidder's organizational information as it relates to the bidder's ability to perform the activities as presented in Section Two.

B.3.1. Section Three of the bidder's response must describe the background and experience of the bidder's organization and subcontractors (if any) and include details regarding its size and resources, its experience relevant to the functions to be performed under the contract resulting from this RFP or recent contracts for similar services.

B.4. Bidder's Proposal – Section Four: A separate section labeled "Section Four – Sample Documents and Exhibits" must contain only those sample documents and exhibits that are expressly permitted or expressly required in the RFP.

B.5. Bidder's Proposal – Section Five: A separate section labeled "Section Five – Business (Cost) Proposal" must contain the bidder's cost and price information in response to the RFP requirements.

B.6. The Department will evaluate each Proposal Section separately in sequence.

C. Delivery Condition – Copies Necessary

C.1. The original (clearly marked) and eight (8) exact, legible copies of the proposal with the designated separate sections - (Section One: Transmittal and Assurances; Section Two: Scope of Work Requirements; Section Three: Organization, Project Management and Key Personnel; Section Four: Sample Documents and Exhibits; and Section Five: Business (Cost) Proposal) must be submitted by the stated deadline in sealed container(s) properly marked "MEDICAL ASO RFP"..

D. Proposal Construction Requirements

D.1. Binding of Proposal - Bidders must submit proposals that coincide with the RFP Table of Contents in a format that will allow updated pages to be easily incorporated into the original proposal. The original (clearly marked – Medical ASO RFP) and eight (8) exact, legible copies of the Proposal must be submitted in loose leaf or spiral bound notebooks. The official name of the organization must appear on the outside front cover of each binder and on each page of the proposal. Location of the name is at the bidder's discretion.

D.2. Tab Sheet Dividers - A tab sheet keyed to the table of contents must separate each major section and subsection of each part of the proposal. The title of each major section and subsection must appear on the tab sheet.

D.3. Table of Contents - Each proposal must incorporate a complete Table of Contents in Part One. It is through this Table of Contents that the Department will evaluate conformance to uniform proposal content and format.

D.4. Cross-referencing RFP and Proposal - All responses must correspond to the specific assigned task number in the RFP and shall follow the sequence order found in the RFP. Each section and subsection of the proposal must cross-

reference the appropriate section and subsection of the RFP that is being addressed. Proposal responses to specific task requirements must reference the RFP request citation. This will allow the Department to determine uniform compliance with specific RFP requirements.

D.5. Page Numbers - Each page of each part of the proposal must be numbered consecutively in Arabic numerals from the transmittal page.

D.6. Page Limitations

D.6.1. Part One – Section One has no page limitations. All forms shown as Appendices in this RFP and submitted in Part One – Section One of the proposal are not subject to page limitations.

D.6.2. Part One – Section Two is limited to 65 pages (double-sided) or 130 pages (single).

D.6.3. Part One – Section Three is limited to 35 pages (double-sided) or 70 pages (single), not including resumes or job descriptions.

D.6.4. Part One - Section Four has no page limits.

D.6.5. Part One – Section Five Business (Cost) Proposal is limited to 15 pages (double-sided) or 30 pages (single) not including audit information and corporate disclosure information.

D.7. Page Format: The standard format to be used throughout the proposal is as follows:

D.7.1. Text shall be on 8 ½” x 11” paper in the “portrait” orientation.

D.7.2. Text shall be single-spaced.

D.7.3. Font shall be a minimum of twelve (12) point in Arial (not Arial narrow) or Times New Roman (not Times New Roman Condensed) font as used in Microsoft® Word.

D.7.4. The binding edge margin of all pages shall be a minimum of one and one half inches (1 ½”). All other margins shall be 1”.

D.7.5. Graphics may have a “landscape” orientation, bound along the top (11”) side. If oversized, graphics may have a maximum of one (1) fold.

D.7.6. Graphics may have a smaller text spacing, pitch, and font size.

D.7.7. Resumes are considered text not graphics.

SECTION IV: PROPOSAL CONTENTS

A. Section One: Transmittal Communication, Forms and Acceptances

A.1. Section One of the original proposal (clearly marked) and each of the eight (8) exact copies of the proposal must include the following in the specified order.

A.1.1. Amendment Acknowledgement: The bidder must insert acknowledgement of the receipt of all amendments issued to bidders.

A.1.2. Transmittal Letter: A Transmittal Letter of no more than four (4) pages signed by a corporate officer with the authority to bind the bidder that addresses:

A.1.2.1. Each of the Bidder assurances (RFP Section II - O 1 through 9);

A.1.2.2. The following identifying information:

A.1.2.2.1. Full Legal name of the corporation and address.
A.1.2.2.2. Federal Taxpayer Identification Number.
A.1.2.2.3. Name, title, and telephone number of the individual with authority to bind the bidder to sign a contract with the Department.
A.1.2.2.4. Name, title, telephone number and e-mail address of the bidder's principal contact to receive amendments to the RFP and requests for clarification.

A.1.3. Table of Contents - for the entire Proposal beginning with the Transmittal Letter.

A.1.4. Identification of any Proprietary Information -See RFP Section II – R

A.1.5. Procurement Agreement Signatory Acceptance – Appendix A

A.1.6. Notification to Bidders/ Workforce Analysis Form - Appendix B - This information must include a signed statement of the bidder's affirmative action plan and the bidder's affirmative action policy statement. Additionally, bidders must address in writing the following five factors as appropriate to the bidder's particular situation. These factors are:

A.1.6.1. Affirmative Action Plan: The bidder's success in implementing an Affirmative Action Plan;

A.1.6.2. Development of Affirmative Action Plan: The bidder promises to develop and implement a successful Affirmative Action Plan if no successful Affirmative Action Plan is in place;

A.1.6.3. Apprenticeship Program: The bidder's success in developing an apprenticeship program complying with Sections 46 a-68-1 to 46a-68-17 of the Regulations of Connecticut State Agencies, inclusive;

A.1.6.4. EEO-1 Data: The bidder's submission of EEO-1 data indicating that the

composition of its work force is at or near parity when compared to the racial and sexual composition of the work force in the relevant labor market area; and

A.1.6.5. Set-Aside for Minority Business: The bidder's promise to set-aside a portion of the contract for legitimate minority business enterprises, and to provide the Department's Set-Aside reports in a mutually agreed upon format

A.1.7. Lobbying Restrictions – Appendix C - The bidder must include a signed statement to the effect that no funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member or Congress, an officer or employee of Congress or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

A.1.8. Consulting Agreement - Appendix D - The bidder must include a signed and notarized Gift/Campaign Contribution Affidavit statement regarding the giving of gifts or campaign contributions to any state official or employee of the Department of Social Services or any state official or employee of any state agency which has supervisory or appointing authority over the Department, including, the Governor's Office, the Office of the Attorney General and the Office of Policy and Management during the two-year period preceding the submission of the proposal.

A.1.9. State of Connecticut Mandatory Terms and Conditions - Appendix E - These terms and conditions are required elements in the contract that results from this procurement.

B. Section Two: Scope of Work (65 double-sided pages)

B.1. Due to the substantive nature of the Scope of Work, the Department has created a separate section of the RFP solely for the Scope of Work. The Scope of Work is outlined in Section V of the RFP.

B.2. Section Two must demonstrate the ability of the bidder to perform all functions within the Scope of Work as outlined in Section V of this RFP. The bidder must respond to all questions in the Scope of Work section.

B.3. The following components make up the Scope of Work:

B.3.1. Overview and Five Year Strategic Plan Contract Management

B.3.2. Eligibility

B.3.3. Utilization Management

B.3.4. Intensive Care Management

B.3.5. Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT)

B.3.6. Coordination of Physical and Behavioral Health Care

B.3.7. Coordination with Home and Community Based Waiver Programs

B.3.8. Analytics/Health Informatics

B.3.9. Quality Management

B.3.10. Provider Relations

B.3.11. Provider Network

B.3.12. Member Services

B.3.13. Telephone Call Management

B.3.14. Data Reporting Requirements

B.3.15. Information

B.3.16. Notice of Action, Denial Notices, Appeals and Administrative Hearings

B.3.17. Provider Appeals

B.3.18. Security and Confidentiality

B.3.19. Contract Compliance, Performance Standards, and Sanctions

B.3.20. Performance Targets and Withhold Allocations

B.3.21. Transition Requirements

B.3.22. Contract Implementation, Review and Termination Provisions

B.3.23. Staffing, Resources and Project Management

C. Section Three: Organization, Project Management; Key Personnel (35 double-sided pages)

C.1. Section Three must describe the background and experience of the bidder's organization and Subcontractors (if any) and include details regarding its size and resources, its experience relevant to the functions to be performed under the contract resulting from this RFP and recent contracts for similar services. All corporation identifiable aspects of the services described in this RFP must be addressed in Part One – Section Three in the following order:

C.1.1. Organization: Corporate Project Unit: The Bidder Shall:

C.1.1.1. Provide a functional organization chart detailing how the proposed project structure fits within the entire structure.

C.1.1.2. Describe how the proposed organizational structure will manage and operate the project proposed by the bidder.

C.1.1.3. Justify its staffing resources to successfully meet its RFP response requirements in light of any other similar obligations for any other entity and the names of bidder personnel proposed for this project.

C.1.2. Key Positions/ Personnel and Staff Resources:

C.1.2.1. The resultant Contractor must receive the written approval of the Department for initial staff as well as changes in key personnel prior to such changes being made.

C.1.2.2. The resultant Contractor shall submit to the Department for its approval, the name and credentials of any persons who are proposed to replace existing or previously proposed project management staff, or other key personnel identified by the Department. These changes must not negatively impact the Department or adversely affect the ability of the Contractor to meet any requirement or deliverable set forth in this RFP and/or the resultant contract.

C.1.2.3. The Bidder Shall

C.1.2.3.1. Identify Key Positions – those positions that will be responsible for the operation and success of the ASO

C.1.2.3.2. Describe a management plan for the project that includes at a

minimum:

C.1.2.3.2.1. A description of the duties, authority and responsibilities of each of the key position/personnel, including the number and type of personnel to be supervised by each;

C.1.2.3.2.2. A complete description of the employment status with the Contractor if the Key positions/personnel are not full-time staff of the Contractor;

C.1.2.3.2.3. An organizational structure of the company indicating lines of authority; and Identification of any other current or planned contractual obligations that might have an influence on the bidder's capability to perform the work under a contract with the Department.

C.1.2.3.2.4. Identify a Project Manager who will be responsible for the implementation and management of the project, for monitoring and ensuring the performance of duties and obligations under a contract, the day to day oversight of the project and who will be available to attend all project meetings at the request of the Department.

C.1.2.3.2.4.1. The Project Manager must be permanently located in the Connecticut office. The Project Manager will respond to the Department's requests for status updates, and ad hoc and interim reports.

C.2. Resumes - The Bidder Shall

C.2.1. Include proposed personnel job descriptions and resumes for key personnel (including the Project Manager) indicating contract-related experience, credentials, education and training, and work experience.

C.2.2. Resumes of personnel proposed for key positions are limited to two (2) pages per resume and must include:

C.2.2.1. Experience with bidder (or Subcontractor);

C.2.2.2. Relevant education, experience, and training;

C.2.2.3. Names, positions, titles, and telephone numbers of persons who are able to provide information concerning the individual's experience and competence; and

C.2.2.4. Each project referenced in a resume should include the customer, and a brief description of the responsibility of the individual to the project.

C.3. Personnel and Tasks - The Bidder Shall

C.3.1. Describe the relationship between specific key personnel, for whom resumes have been submitted, and the specific tasks and assignment proposed to

accomplish the scope of work.

C.4. Availability of Staff - The Bidder Shall:

C.4.1. Propose a plan to maintain staff twenty-four hours per day and seven days per week. The plan should fully describe peak and limited service times citing prior experience.

C.5. Evidence of Qualified Entity – The Bidder Shall:

C.5.1. Provide written assurance to the Department from its legal counsel that it is qualified to conduct business in Connecticut and is not prohibited by its articles of incorporation, bylaws, or the law under which it is incorporated from performing the services required under any resultant contract.

C.6. Location of Bidder Facilities - The Bidder Shall:

C.6.1. Identify or propose its Connecticut location and identify any other state where the bidder or its parent has a principal place of business.

C.7. Governance – Disclosure – The Bidder Shall:

C.7.1. Provide the following information for the bidder as the proposed prime contractor and any proposed subcontractor:

C.7.1.1. The name, work address, home address, gender, and percentage of time spent on the contract resulting from this RFP of each responsible director.

C.7.1.2. The role of the board of directors in governance and policy making.

C.7.1.3. The manner in which clients are to be represented, if any, in an advisory or decision-making capacity concerning the contract.

C.7.1.4. A current organizational chart defining levels of ownership, governance and management.

C.8. Ownership – Disclosure - The Bidder shall provide the following:

C.8.1. A complete description of percent of ownership by the principals of the company or any other individual or organization who retain 5% or more including: name, work address, home address, and gender.

C.8.2. The relationship of the persons so identified to any other owner or governor as the individual's spouse, child, brother, sister, or parent.

C.8.3. The name of any person with an ownership or controlling interest of five percent or more, in the bidder, who also has an ownership or control interest of five percent or more in any other related entity including subcontracting entity or parent entity or wholly owned entity. The bidder shall include the name or names of the other entity.

C.8.4. The name and address of any person with an ownership or controlling interest in

the disclosing entity or is an agent or employee of the disclosing entity who has been convicted of a criminal offense related to that person's involvement in any program under Title XVIII, XIX, XX or XXI of the Social Security Act, since the inception of such programs.

C.8.5. Whether any person identified in subsections (a) through (d) above, has been terminated, suspended, barred or otherwise excluded from participation, or has voluntarily withdrawn as the result of a settlement agreement, from any program under Titles XVIII, XIX, XX or XXI of the Social Security Act, or has within the last five years been reinstated to participation in any program under Titles XVIII, XIX, XX or XXI of the Social Security Act, and prior to said reinstatement had been terminated, suspended, barred or otherwise excluded from participation, or has voluntarily withdrawn as the result of a settlement agreement, in such programs.

C.8.6. A description of the relationship with other entities including:

C.8.6.1. Whether the bidder is an independent entity or a subsidiary or division of another company. If the bidder is not an independent entity, the bidder shall describe the organization linkages and the degree of integration/collaboration between the organizations including any roles of the organization's principals; and

C.8.6.2. A complete listing and explanation of any financial relationship with any other health management or consulting organization.

C.9. Accreditation, Licensure and QIO-Like Status - The Bidder shall:

C.9.1. Provide documentation of any accreditation by a nationally recognized accrediting body and licenses held relative to functions required by this RFP.

C.9.2. Be required to be a QIO or QIO-like entity in Connecticut at the time of application or no later than January 1, 2012. The Bidder shall demonstrate the following:

C.9.2.1. Its understanding of the requirements for obtaining QIO or QIO-like designation in Connecticut within the required timeframes and

C.9.2.2. A methodology for time study and cost allocation necessary to support a claim for enhanced match for professional medical review services rendered by the Contractor.

C.10. Organization: Qualifications and Corporate Experience - The Bidder shall:

C.10.1. Describe the bidding organization's overall qualifications to carry out a project of this nature and scope. The detail of corporate experience and success relevant to the "MEDICAL ASO RFP" scope of work for this project should include the following information concerning the bidder's experience in other contracts or projects, whether ongoing or completed:

C.10.2. Disclose all other state agency(s) in all states or commercial vendors with

which bidder had a contract for the administration of Medicaid programs or other public health care programs in the past five years. Describe the nature of contract, and identify those contracts that are (were) similar to the scope of work for this project. For those contracts identified as similar to the scope of work for this project the Bidder shall provide responses to the following:

C.10.2.1. A description of its projects or the work performed in the past five years for those agencies or commercial vendors.

C.10.2.2. A signed release allowing the Department to access any evaluative information including but not limited to site reviews conducted by any state agency or commercial entity for which the bidder has performed work in the past five years.

C.10.2.3. Contacts for those projects including: name of customer's project officer, title, address and telephone number. The Department reserves the right to contact the Medicaid director or similarly situation individual in any state within which the bidder has administered Medicaid covered services.

C.10.2.4. The amounts of initial and final contracts.

C.10.2.5. Identification of subcontractors used and a description of their responsibilities under the contract.

C.10.2.6. The term of the contracts including the date of contract signing, the date of project initiation, the initial schedule completion date and the actual completion date.

C.10.2.7. A description of the project services provided and where project services can be quantified, a disclosure of the level of services provided, i.e.: the number of prior authorizations and type reviewed.

C.10.2.8. For similar contracts requiring prior authorization services, a description of the response time for prior authorization.

C.10.2.9. A description of the linkage with the data systems in those states.

C.10.3. Describe the bidding organization’s ability to secure and retain professional staff to meet the contract requirements.

C.10.4. Provide a written assurance that the company, its principals and staff will avoid real or perceived conflicts of interest and that staff will have no relationships with health care providers during the term of the contract that conflict with the goals and intent of this project. For purposes of this contract, a conflict for the organization and staff person would arise when a staff person would benefit materially from a relationship with a health care provider including but not limited to:

C.10.4.1. When a staff person provides information on behalf of a provider to the

resulting Contractor and benefits materially from that information sharing;

C.10.4.2. When a staff person or his/her agency/firm has agreed to be a subcontractor for services resulting from any resultant contract; and

C.10.4.3. When a staff person serves on the Board of Directors of a health care provider.

C.10.5. Provide a written assurance that should the bidder become aware of a potential or perceived conflict that may compromise the bidder's objective provision of services under the resultant contract, the bidder shall discuss this situation with the Department's Contract Administrator. The Contract Administrator will determine the necessary remedy.

C.11. Bidder References (Organization): The Bidder shall:

C.11.1. Supply Corporation Reference Contacts for all contracts identified in Section C.12.2 of this RFP including names, phone numbers and e-mail addresses for the reference.

C.11.1.1. Corporation references are individuals that are able to comment on the performance of the bidding organization's capacity to perform work. The contact person must be an individual familiar with the performance of the organization and its day-to-day performance on the identified contract. This request for corporation references is in addition to the request for references for key personnel. The Department expects to utilize these references in its evaluation process.

C.12. Subcontracts: The Contractor may subcontract for any function, excluding Telephone Call Management and Member Services. The following provisions of this section apply to those subcontractors retained by the Contractor for the purposes of providing the contractor's requirements. For each subcontract arrangement the Contractor shall be required to comply with following contractual conditions in addition to those Terms and Conditions approved by the Attorney General.

C.12.1. The Contractor shall be held directly accountable and liable for all of the contractual provisions resulting from this RFP regardless of whether the Contractor chooses to subcontract its responsibilities to a third party.

C.12.2. No subcontract shall negate the legal responsibilities of the Contractor as articulated in any resultant contract including those responsibilities that require the Contractor to assure that all activities carried out by the subcontractor conform to the provisions of the Contractor's contract with the Department.

C.12.3. All subcontracts shall be written and incorporate the following conditions:

C.12.4. All subcontracts shall include any general requirements of Contractor's contract with the Department in response to this RFP that are appropriate to the

services provided by the subcontractor;

C.12.5. All subcontracts shall provide for the right of either of the Department or other governmental entity to enter the subcontractor's premises to inspect, monitor or otherwise evaluate the work being performed as a delegated duty by the Contractor.

C.12.6. The Contractor and its subcontractors shall cooperate in the performance of financial, quality or other audits conducted by the Department or its agent(s).

C.12.7. The Contractor shall provide upon the Department's request a copy of any subcontract.

C.12.8. The Bidder shall:

C.12.9. Identify any of the services where the bidder intends or is contemplating utilizing a subcontractor to perform the services or duties of the Contractor.

C.12.10. Identify subcontractors and describe their experience and qualifications.

C.12.11. For each identified subcontractor submit four (4) references who can attest to the subcontractor's past performance in contracts of a similar nature and scope.

C.12.12. Describe the means the Bidder used to select the subcontractor or if a subcontractor has not been selected to provide a specific service, but a decision has been made to subcontract a particular service describe the minimum experience and qualifications required to perform any intended subcontracted service.

C.12.13. Provide the subcontractor's name, address, duties of the subcontractor and the maximum payment under the subcontract. Propose a methodology to conduct oversight of its subcontractors performing any services.

C.12.14. Describe the processes for managing subcontracts.

C.13. Application of New or Innovative: - The Bidder Shall

C.13.1. Describe any applications of new or innovative technologies that would add value to the proposed contract, and

C.13.2. State whether these technologies are included in the Full Scope or Reduced Scope option.

C.14. Customer Service, Training, and Education: - The Bidder Shall:

C.14.1. Provide and describe examples of its member Training and Education program activities, regarding medical related issues that are used by the Bidder to promote an emphasis on person-centered approach to care.

C.14.2. Describe the goal of each activity, the method used to measure the success at achieving these goals and the outcomes. The bidder may include in Section Five any samples of formal presentation material including training materials used in its program(s).

C.15. Professional Rapport and Collaboration: The implementation of the Department's vision for an integrated medical system will depend in part upon the ASO's ability to elicit cooperation from providers of care and other interested parties and to collaborate with the Department and affiliated agencies. The Bidder Shall:

C.15.1. Fully describe its competence in eliciting cooperation and collaboration from the various entities including its experience as an organization and the experience of specific individuals. The description must include an explanation of how the Bidder plans to establish positive working relationships with the medical providers and constituent groups.

C.16. Small, Minority or Women's Business Enterprise - Section 32-9e of the Connecticut General Statutes sets forth the requirements of each executive branch agency relative to the Connecticut Small Business Set-Aside program. Pursuant to that statute, twenty-five (25%) of the average total of all contracts for each of the three previous fiscal years must be set aside. The Department requires that the resultant Contractor make a "good-faith effort" to set aside a portion of the contract resulting from this RFP for a small, minority or women's business enterprise as a subcontractor. Such subcontractors may supply goods or services. Prospective bidders may obtain a list of firms certified to participate in the Set-Aside program by contacting the Department of Administrative Services at the DAS website: http://das.ct.gov/cr1.aspx?page=34 or by calling (860) 713-5236. The Bidder Shall

C.16.1. describe its effort to set aside a portion of the contract resulting from this RFP for a small, minority or women's business enterprise as a subcontractor. During the evaluation process special consideration will be given to those bidders who document their utilization of a certified small business and/or demonstrate the bidder's commitment to, whenever possible, utilize a certified small business.

C.17. Department Responsibilities: - The Bidder Shall:

C.17.1. propose specific support the bidder requires from the Department to perform the tasks proposed in any resultant contract. Notwithstanding any bidder's proposed tasks for the Department to the contrary, the Department shall:

C.17.1.1. Monitor the Contractor's performance and request updates as appropriate.

C.17.1.2. Respond to written requests for policy interpretations.

C.17.1.3. Provide technical assistance to the Contractor as necessary. Allow access to automated databases as available and permitted.

C.17.1.4. Allow access to management reports and case files as appropriate.

Provide a designated contract manager.

C.17.1.5. Schedule and hold regular project meetings with the Contractor.

C.17.1.6. Provide a process for and facilitate open discussions with staff and personnel to gather information regarding recommendations for improvement.

C.17.1.7. Provide data as required by the Contractor to perform the Medical functions.

C.17.1.8. Conduct appeals with participation and input from the Contractor as determined by the Department.

C.18. Project Timetable: - The Bidder Shall submit a PERT, Gantt, or Bar Chart, that clearly outlines the task timetable for the implementation of MEDICAL ASO services from beginning to end. The chart must display key dates and events relative to the project and the position and title of the responsible party.

C.19. Identifiable Narrative Examples and Samples: - The Bidder Shall provide a summary of its experience with respect to the following areas of health services administration:

C.19.1. Member and Provider Services and Call Center: - Experience in providing member and provider services including the operation of a locally based call center for persons who are elderly or disabled, including persons with hearing impairments, children with special health care needs, or other individuals experiencing one or more chronic health care conditions.

C.19.2. Authorization interface: - Experience in the development and maintenance of an authorization interface with a state administered Medicaid Management Information System for the authorization of services for the processing of claims.

C.19.3. Eligibility files: - Experience importing, cleaning, maintaining and managing eligibility files.

C.19.4. Provider files: - Experience importing, cleaning, maintaining and managing a provider file where the source provider file is created and maintained by a separate entity, which sends the bidder periodic updates of provider information such as adds and deletes.

C.19.5. Data Analytics: - Experience in providing data analytics for population health management, health risk stratification, provider and client profiling, and disease management. Provide examples of the effective use of data analytics for population health management, health risk stratification or disease management.

C.19.6. Clinical Management: Experience with providing clinical management services such as health risk assessment, disease management, utilization management, consumer health information, care planning, care management and case management, and quality management with high risk and chronic illness

populations.

C.19.6.1. Provide specific examples of ICM or similar comprehensive care management programs that the bidder has implemented in other contracts and how the bidder ensured a person-centered approach.

C.19.6.2. Provide a review of each of the examples including reasons for success and lessons learned.

C.19.6.3. Describe the bidder's experience with coordinating primary care, specialty medical, dental, pharmacy and behavioral health services. Include in this description, at a minimum, challenges the organization has encountered in collaborating with providers and other ASOs or carveouts as well as solutions considered and implemented.

C.19.6.4. Provide examples of how the bidder identified and addressed provider specific quality issues in other public programs operated by the bidder.

C.19.6.5. Provide examples of the provider's use of provider profiling methodologies and describe how provider profiling information was shared with providers and individuals served by the system.

C.19.6.6. Provide a description of the bidder's experience applied to public sector health programs in addressing the cultural and linguistic needs of individuals and proposed adaptation for Connecticut individuals;

C.19.6.7. Provide one or more examples of efforts undertaken by the bidder to improve member service performance; and

C.19.6.8. Provide examples of Security and Privacy Plan policies and procedures of the type required in Section V, W.3.1, Security and Confidentiality.

D. Section Four: Sample Documents and Exhibits

D.1. Section Four must contain only those sample documents and exhibits that are expressly permitted or expressly required in the RFP. In addition to those sample documents and exhibits that are expressly permitted in the RFP the Bidder shall submit the following:

D.1.1. Sample UM policies and procedures related to prior authorization, concurrent reviews, discharge reviews, and retrospective reviews from other public sector programs administered by the bidder.

D.1.2. An example of the bidder's QM policies and procedures including procedures related to the management of provider specific quality incidents from other public sector programs administered by the bidder.

D.1.3. An example of the bidder's member services policies and procedures from other

public sector programs administered by the bidder.

D.1.4. A sample provider handbook that the bidder has developed for other public sector health programs.

D.1.5. A sample member brochure and member handbook that the bidder has developed for other public sector health programs.

D.1.6. Samples of provider profiling reports including hard copy static reports and/or print screen examples of electronic profiling software.

E. Section Five: Business (Cost) (15 double-sided pages)

E.1. Business – Cost - Section Five must contain the Bidder's cost and price information in response to the RFP requirements. The bids in this proposal are to remain fixed by phase for the term of the contract and represent the total fees for the scope of work required by the RFP.

E.2. For Section Five of the Bidders' proposal the Bidder Shall include cost information and other financial information in the following order:

E.2.1. Financial Information - The Proposal must provide bidder specific information as described below:

E.2.1.1. Audited Financial Statements for the two most recent fiscal years for which the statements are available. The statements must include a balance sheet, income statement and a statement of changes in financial position. Statements must be complete with opinions, notes and management letters. If no audited statements are available, explain why and submit un-audited financial statements.

E.2.1.2. Lines of Credit: Documentation of lines of credit that are available, including maximum credit amount and available amount.

E.2.1.3. Debt Ratings: Short-term and long-term debt ratings by at least one nationally recognized rating service, if applicable.

E.2.1.4. Analysis and evaluation of future financial condition and stability.

E.2.2. Business Narrative The proposal must include a narrative that explains and details the projected costs under the contract resulting from this RFP. There must be a separate narrative for each bid option (A1/A2 and B1/B2). A separate narrative is not required for the reduced enrollment options.

E.2.3. Cost Proposal - The Department is soliciting bids responsive to the scope of work as outlined in this document. The Bidder Shall provide two sets of bids corresponding to the following options as described in Section I B – Program Description:

E.2.3.1. Full Scope – Option A1 (full enrollment) and A2 (half enrollment)

E.2.3.2. Reduced Scope – Option B1 (full enrollment) and A2 (half enrollment)

E.2.4. Complete the Budget Template in Exhibit F for Options A1/A2 and B1/B2, by phase.

E.2.4.1. Provide the PMPM for the administrative services required to meet the requirements of this RFP and corresponding budget responsive to each of the

aforementioned scope options.

E.2.4.2. Identify any additional costs associated with the services specified in this RFP that are not included in the costs quoted above.

E.2.5. Although a PMPM calculation is required in the response template, the final contract will be fixed cost. Profit will be calculated as a percent of the total administrative contract cost and shall be 7.5%. The 7.5% profit shall be withheld and payable only to the extent that the Contractor meets the Performance Targets established in this RFP.

E.2.6. Describe how the Contractor will monitor and respond to increases in enrollment that surpass projected enrollment in terms of deploying or adjusting staffing for specific administrative functions (e.g., Utilization Management, Member Services, Intensive Care Management). This response must specifically address how the additional administrative revenues would be distributed to the administrative functions.

E.2.7. For years two (2) through five (5) of the contract, specify the maximum percentage increase in administrative cost, excluding changes in enrollment, and on what assumptions any cost increase is based.

E.2.8. Identify other costs not included in the above cost proposals:

E.2.9. Provide a full explanation of the cost for the Member brochures discussed in the Member Services section separating original design, printing, distribution, and revision costs.

E.2.10. Provide your hourly programming cost for Special Report related programming that exceeds the 200 hours allocated for such reports in the Data Reporting Requirements section.

SECTION V: SCOPE OF WORK AND WORKPLAN MANAGEMENT

A. Overview and Five Year Strategic Plan

A.1. The Department's primary goal is to improve quality of care and the care experience for our members, while reducing cost. Secondary goals include fostering change in local service delivery through the provision of performance data and technical assistance to support the emergence of medical homes and integrated care organizations.

A.2. The Department seeks to achieve substantive improvements in service access, appropriateness and quality while reducing expenditures. The bidder will propose a strategic business plan for the targeted deployment of administrative resources to achieve these goals over the course of the 5-year contract. This initial plan must be fully responsive to the scope of work and will be referred to as FULL SCOPE – OPTION A.

A.3. The bidder will also propose a reduced scope option, REDUCED SCOPE – OPTION B. The bidder should propose reductions in scope that would optimize the value of the Contractor's services relative to the goals of the Department, while reducing the overall cost of the Contract. Reductions might include the elimination of functions, reducing the scope or extent of various functions, or easing proposed timeframes.

A.3.1. In the reduced scope option, the bidder should attempt to provide the greatest value possible for the lowest price possible. The bidder should indicate whether, how and to what extent the proposed reductions would affect the bidder's ability to achieve the Department's goals.

A.4. The Department may select one bidder or multiple bidders to carry out the requirements of the contract resulting from this RFP. Accordingly, the Department is requiring that the bidder submit two bids for each of the above options, the first of which shall be based on full enrollment and the second of which shall be priced under the assumption that enrollment will be divided among two or more bidders.

A.5. The Bidder Shall

A.5.1. Provide an overview of the bidder's approach to this scope of work and to realizing the goals established by the Department, and for making the most of the bidder's expertise and administrative resources.

A.5.2. Propose a strategic business plan for the targeted deployment of administrative resources to achieve the Department's goals over the course of the 5-year contract. This plan should be responsive to the full scope of work outlined in this RFP.

A.5.3. Propose a reduced scope strategic business plan for the targeted deployment of administrative resources to achieve the Department's goals over the course of the 5-year contract. This plan should reduce the overall cost of the contract, while

minimizing the loss of administrative value.

A.5.4. For REDUCED SCOPE - OPTION B, the bidder should describe material alterations to the RFP requirements that might result in a more cost-effective strategy for achieving the Department's goals. The bidder must specify and clearly identify such departures in the proposal. The bidder shall complete the Scope of Work Options Synopsis (Exhibit B) to facilitate comparison of the bidder's Reduced Scope Option to its Full Scope Option. The Bidder's Section Two shall make appropriate notation where a function would be reduced or eliminated under OPTION B.

A.5.5. Complete the Scope of Work Options Synopsis (Exhibit B) to facilitate comparison of the bidder's proposed options.

A.1.1. The bidder's responses to each subsection of Section IV, Part Two should make appropriate notation where a function would be reduced or eliminated under OPTION B.

B. CONTRACT MANAGEMENT AND ADMINISTRATION

B.1. Contract Oversight

B.1.1. The Department shall designate a Contract Manager (hereinafter referred to as "Contract Manager") to oversee management of the contract that is awarded pursuant to this proposal including the performance of the Contractor.

B.1.2. The Contract Manager will be the Contractor's first contact regarding issues that arise related to Contract implementation, operations, and program management. The Contract Manager will be responsible for overseeing and managing the Contractor's performance according to the terms and conditions of the Contract; responding to all Contractor inquiries and other communications related to implementation, operations, and program management; and rendering opinions or determinations with respect to applicable state and federal regulations and policies as the need arises and upon request of the Contractor.

B.1.3. The Department may, at its discretion, station one or more of its employees on-site at the Contractor's place(s) of business to provide consultation, guidance and monitoring regarding the administration of the contract resulting from this RFP.

B.2. Key Person

B.2.1. The Contractor shall designate a key person to be responsible for all aspects of the Contract and the Contractor's performance with respect to said Contract. This key person shall be responsible solely for all Connecticut-based operations, with authority to reallocate staff and resources to ensure contract compliance. Contractor's corporate resources shall also be provided to assist the Contractor in complying with contractual requirements.

B.2.2. The Contractor's key person must be approved by the Department. Such

designation shall be made in writing to the Contract Administrator within five (5) working days of execution of the contract resulting from this RFP, and notification of any subsequent change of the key person shall be made in writing to the Contract Administrator for approval prior to such change.

B.2.3. The Contractor's key person shall immediately notify the Contract Manager of the discharge of any personnel assigned to the contract resulting from this RFP and such personnel shall be immediately relieved of any further work under the contract resulting from this RFP. The Contractor's key person or designee shall be the first contact for the Department regarding any questions, problems, and any other issues that arise during implementation and operation of the Contract.

B.3. Key Positions and Personnel

B.3.1. Key positions shall mean executive or managerial positions. Key personnel shall mean people in the key positions. The Contractor's key positions and key personnel must be approved by the Department. Such designations shall be made in writing to the Contract Manager by November 1, 2011. No changes, substitutions, additions or deletions, whether temporary or permanent shall be made unless approved in advance by the Department, whose approval shall not be unreasonably withheld.

B.3.2. During the course of the contract resulting from this RFP the Department reserves the right to require the removal or reassignment of any Contractor personnel or subcontractor personnel assigned to the contract resulting from this RFP found unacceptable by the Department. Such removal shall be based on grounds which are specified in writing to the Contractor and which are not discriminatory.

B.3.3. The Contractor shall notify the Department in the event of any unplanned absences longer than seven days of key personnel and provide a coverage plan.

B.4. Contract Administration

B.4.1. The Contractor shall raise technical matters associated with the administration of the Contract including matters of Contract interpretation and the performance of the State and Contractor in meeting the obligations and requirements of the Contract with the Contract Manager.

B.4.2. When responding to written correspondence by the Department or when otherwise requested by the Department, the Contractor shall provide written response.

B.4.3. The Contractor shall address all written correspondence regarding the administration of the Contract and the Contractor's performance according to the terms and conditions of the Contract to the Contract Manager.

B.4.4. The Contractor shall coordinate directly with the appropriate Department representatives as directed by the Contract Manager when issues arise involving

clinical care, quality of care, or safety of a member.

B.4.5. The Contractor's key person or designee shall respond to telephone calls from the Department within one (1) business day.

B.5. Deliverables – Submission and Acceptance Process

B.5.1. The Contractor shall submit to the Department certain materials for its review and approval. For purposes of this section, any and all materials required to be submitted to the Department for review and approval shall be considered a "Deliverable".

B.5.2. The Contractor shall submit each Deliverable to the Department's Contract Manager. As soon as possible, but in no event later than 30 Business Days or such other date as agreed to by the parties in writing, after receipt (not counting the date of receipt) of a Deliverable, the Department's Contract Manager shall give written notice of the Department's unconditional approval, conditional approval or outright disapproval. Notice of conditional approval shall state the conditions necessary to be met to qualify the Deliverable for approval.

B.5.3. s soon as possible, but in no event later than 10 Business Days or such other date as agreed to by the parties in writing, after receipt (not counting the date of receipt) of a Notice of conditional approval or outright disapproval, the Contractor shall make the corrections and resubmit the corrected Deliverable.

B.5.4. As soon as possible, but in no event later than 10 Business Days or such other date as agreed to by the parties in writing, following resubmission of any Deliverable conditionally approved or outright disapproved, the Department's Contract Manager shall jointly give written notice of the Department's unconditional approval, conditional approval or outright disapproval.

B.5.5. In the event that the Department's Contract Manager fails to respond to a Deliverable (such as, to give notice of unconditional approval, conditional approval or outright disapproval) within the applicable time period, the Deliverable shall be deemed unconditionally approved.

B.5.6. Whenever the due date for any Deliverable, or the final day on which an act is permitted or required by the contract resulting from this RFP to be performed by either party falls on a day other than a Business Day, such due date shall be the first Business Day following such day.

B.6. Committee Structure

B.6.1. The Contractor shall establish committees with family, consumer, and provider representation to provide advice and guidance to the Department and the Contractor regarding the scope of clinical and administrative services under the contract resulting from this RFP. The Contractor shall submit a plan for the establishment or use of such committees to the Department for approval by

November 1, 2011 and when changes are made thereafter.

B.7. Participation at Public Meetings

B.7.1. The Contractor shall ensure that the Contractor's key person attends, unless excused by the Department, all of the meetings of any body established to provide legislative oversight of this initiative. The Contractor shall make available appropriate Contractor Key Personnel, as directed by the Department, to attend the meetings of various bodies established to provide input into this initiative or related services, including legislative and other public committees with responsibility for monitoring the budget of the Department.

B.8. Cooperation with External Evaluations

B.8.1. The Contractor shall cooperate with any external evaluations or studies as required by the Department including, but not limited to providing data, reports, and making Contractor staff and records available to the outside evaluators.

B.9. Policy Manual

B.9.1. The Contractor shall produce a single integrated manual of all of the policies and procedures pertaining to services provided under the contract resulting from this RFP. The manual shall include, but is not limited to the specific policies and procedures provided for in subsequent sections of the contract resulting from this RFP, and which may require review and approval of the Department. The Contractor shall post the manual on a website accessible to staff of the Department. The website shall include the current version of the manual and all archived versions of the manual that contain policies in effect at any time following implementation. Certain policies and procedures may be exempt from this requirement with the approval of the Department. The Policy Manual shall be submitted for the Department's approval by February 1, 2012.

B.10. The Bidder Shall:

B.10.1. Describe the Contractor's plan for working with the Department under the above model and provide additional recommendations that would further support this management model including any proposed modifications to the model and corresponding justification.

C. ELIGIBILITY

C.1. Eligibility Determination and File Production and Transmission

C.1.1. The Department shall, in accordance with the Department's individual eligibility policies, determine the initial and ongoing eligibility of each individual enrolled in the Medical Assistance programs that are part of this RFP in accordance with the Department's eligibility policies.

C.1.2. The Contractor will be responsible for maintaining a methodology to verify

Member eligibility for the purpose of performing service authorization requests for Medical Assistance clients.

C.1.3. Coverage for Members can be effective any day of the month. However, coverage for most Members will be effective on the first of the month. Similarly, coverage for most Members will terminate on the last day of the month. Loss of eligibility results in termination of coverage. Coverage for members can terminated any day of the month. However, coverage for most members will terminate on the last day of the month.

C.1.4. The Department of Social Services and its agent will generate and transmit eligibility files to the Contractor. The Contractor will begin with a monthly file of all eligible members for the ongoing month. Daily files will be sent to the Contractor, which will include transactions for “adds” (retroactive, current and ongoing) and deletes (retro, current, and ongoing). At the end of the month, a month-end file will be sent to the Contractor. The Contractor must use the month-end file to reconcile Member eligibility. The files will be placed on a remote server for retrieval by the Contractor.

C.2. Eligibility Verification and Authorization Requests:

C.2.1. The Contractor shall for each authorization request received:

C.2.1.1. Maintain a methodology to verify Member eligibility for the purpose of performing service authorization requests for Members.

C.2.1.2. Receive requests for the authorization of medical goods and services and shall, for each authorization request received, determine whether the individual is eligible for coverage of the good or service using the most recent eligibility file supplied by the Department or its agent.

C.2.1.3. Validate eligibility through the web-based interface with the Department’s Automated Eligibility Verification System (AEVS) if the Contractor is unable to validate eligibility by accessing the file.

C.2.2. If eligibility is verified the Contractor shall obtain third party coverage information pertaining to eligible Medicaid members and shall:

C.2.2.1. notify the Department within seven (7) business days of any inconsistencies between the third party information obtained by the Contractor and the information reflected in the eligibility files or AEVS.

C.2.2.2. Implement one of the following applicable steps when the individual has third party coverage:

C.2.2.2.1. In situations where the services requested are covered by another insurance carrier, the Contractor shall follow the appropriate protocol for determining service authorization, which is further described in the

Utilization Management Section. At a minimum, the Contractor shall:

C.2.2.2.1.1. Inform the provider that Medicaid is the payor of last resort, and the Contractor shall require the requestor to bill other known carriers first, before billing the Department or its designated agent,

C.2.2.2.1.2. Inform the provider to submit a claim to the MMIS vendor only after the other insurance carrier(s) has processed the claim and to follow all applicable Connecticut Medical Assistance Program Provider Manual instructions.

C.2.2.3. In situations where the Member is also Medicare eligible and authorization is sought for a service, the Contractor shall determine whether Medicare covers the requested services and take action as follows:

C.2.2.3.1.1. If Medicare covers the service, the Contractor shall inform the provider that no authorization is necessary since it is a Medicare covered service. The Contractor shall inform the provider to (a) have the claim electronically crossed over from Medicare to Medicaid or (b) submit a claim to the MMIS vendor only after Medicare has processed the claim and to include the applicable Explanation of Medicare Benefits (EOMB) with the claim.

C.2.2.3.1.2. If the service is not a Medicare covered service, the Contractor shall follow the appropriate protocol for determining service authorizations, which is further described in the Utilization Management Section.

C.2.2.4. The Contractor shall report, in a format and timeframe to be determined by the Department when any HUSKY B or Charter Oak member appears to have other insurance.

C.2.2.5. The Contractor shall use the Unique Client Identification Number assigned by EMS (Eligibility Management System) to identify each eligible person. EMS will assign a unique identification number for all individuals covered by the contract resulting from this RFP.

C.2.3. The Bidder Shall:

C.2.3.1. Describe its method to validate eligibility and respond to provider requests including the maximum amount of time from the time of the provider's request to the response to the provider.

D. UTILIZATION MANAGEMENT

D.1. General Provisions

D.1.1. Utilization Management (UM) is a set of Contractor processes that seeks to ensure that eligible members receive the most appropriate, least restrictive, and

most cost effective treatment to meet their identified medical needs.

D.1.2. UM, as used in this RFP, includes practices such as Registration, Prior Authorization, Concurrent Review, Retroactive Medical Necessity Review and Retrospective Utilization Review.

D.1.3. UM shall serve as a primary source of information for providers about the availability of services and the identification of new or alternative services.

D.2. Medical Necessity All decisions made by the Contractor to authorize goods or services shall conform to the statutory definition of medical necessity as follows:

D.2.1. Medical necessity: Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition. Conn. Gen. Stat. § 17b-259b.

D.2.2. The Contractor may use InterQual or Milliman care guidelines, other care/utilization guidelines, clinical guidelines or recommendations of professional societies or specialty organizations in making authorization decisions.

D.2.3. If the medical necessity definition conflicts with any such criteria or guideline, the medical necessity definition shall prevail. Upon denial of a request for authorization of services based on medical necessity, the individual shall be notified that, upon request, the Department of Social Services shall provide a copy of the specific guidelines or criteria, or portion thereof, other than the medical necessity definition provided in D.2.1 of this section that was considered by the Department or an entity acting on behalf of the Department in making the determination of medical necessity.

D.3. Approval of the Contractor’s UM Program

D.3.1. The Department shall review for approval the Contractor’s UM Program, which shall include a program description, flow diagrams, and specific policies and procedures pertaining to UM practices, registration, prior authorization, concurrent review, discharge review, retroactive medical necessity review, retrospective

utilization review, retrospective chart review, and the bypass program.

D.3.2. The Contractor shall provide the Department, for its review and approval, the proposed UM Program by November 1, 2011. The Department shall provide reject or approve the proposed UM Program within 30 days of the Department's receipt of the UM Program. Once the UM Program is approved by the Department, the Contractor shall implement and follow the approved UM Program unless and until such approved program is revised with the approval of the Department. The Contractor shall revise and resubmit the UM Program to the Department for review and approval at least annually and no later than October 1st of each year.

D.4. Design and Conduct of the Utilization Management Program

D.4.1. The Contractor shall design and conduct a UM Program that shall be cost-efficient and quality based. The processes utilized in the UM programs shall:

D.4.1.1. Be minimally burdensome to the provider.

D.4.1.2. Effectively monitor and manage the utilization of specified treatment services.

D.4.1.3. Utilize state-of-the-art technologies including web-based applications for registration, prior authorization, concurrent review, and retrospective review.

D.4.1.4. Promote person centered treatment, recovery and maintenance of health.

D.5. Clinical Review Process

D.5.1. The Contractor's UM Program shall, at a minimum, require the Contractor to conduct reviews of health care services requested by or on behalf of Members in accordance with best, evidence-based clinical practices.

D.5.2. The Contractor shall provide to the Department the methods it proposes to use to identify what are currently considered to be the best evidence-based practices, and when such evidence is lacking or in conflict to support the efficacy of requested health care services, its approach to reviewing and determining whether such requests are medically necessary:

D.5.3. For members receiving services pursuant to an order of the court, requested services shall be authorized if they are determined to be medically necessary.

D.5.4. The Contractor shall conduct periodic reviews of authorized health services for timely and coordinated discharge planning.

D.5.5. The Contractor shall review the Member's current and open authorizations when a new request for authorization is received to determine whether the requested

service is a duplication of, or in conflict with, an existing service authorization.

D.5.6. The Contractor shall verify that the services to be authorized are covered under, and the provider to whom payment would be made is enrolled as an active provider in, the program from which the provider/member is seeking coverage, prior to completing an authorization for service.

D.5.7. The Contractor shall conduct retroactive medical necessity reviews resulting in a retroactive authorization or denial of service for individuals who are retroactively granted eligibility, when the effective date of eligibility spans the date of service and the service requires authorization. The provider shall be responsible for initiating this retroactive medical necessity review to enable authorization and payment for services.

D.5.8. The Contractor shall assist hospital emergency departments with the coordination of care, when requested by the emergency department. For the purposes of this request for proposals, hospital shall mean general acute care hospital including children's hospitals.

D.5.9. The Contractor shall implement a systems-based protocol for checking each service request against Intensive Care Management (ICM) thresholds that might trigger the involvement of ICM staff and shall refer to ICM staff, notifying the member of the referral, if a threshold is triggered.

D.6. Clinical Review Availability and Timelines

D.6.1. The Contractor shall perform admission reviews for acute general hospital, general children's hospital, and chronic disease hospital inpatient services.

D.6.2. Acute inpatient services in a general hospital are payable under Medicaid as a per discharge case rate. Consequently, the Contractor shall only be required to conduct an admission authorization and discharge review for admissions to general hospitals. Additional contacts may be necessary to facilitate timely discharge and to support transitional care coordination.

D.6.3. The Contractor shall propose information content requirements for provider requests for authorization of admission to acute care and chronic disease hospitals for the Department's approval.

D.6.4. The Contractor shall perform prior authorization reviews within the following time frames:

D.6.4.1. The Contractor shall render a decision concerning an elective hospital admission within five business days; an emergency hospital inpatient admission within one business day.

D.6.4.2. The Contractor shall render decisions concerning admission to a chronic disease hospital within two business days.

D.6.4.3. The Contractor shall render a decision on requests for readmission to a chronic disease hospital from an acute care hospital within one business day. Such notice may also be communicated by telephone or electronically.

D.6.4.4. The Contractor shall authorize or deny requests for continued stay in a chronic disease hospital for clients who have exhausted third party insurance. The ASO shall render such an authorization decision within two business days from notification by the chronic disease hospital of the exhaustion of the other benefits.

D.6.4.5. The Contractor shall render a decision concerning an outpatient surgery within 2 business days.

D.6.4.6. The Contractor shall authorize decisions concerning durable medical equipment within fourteen (14) days.

D.6.4.7. The Contractor shall authorize decisions concerning therapies (speech, physical, occupational) within one business day of a new request for authorization.

D.6.4.8. For all other non-emergent services subject to a prior authorization request, the Contractor shall render a decision within fourteen (14) days of the request.

D.6.4.9. The times listed in D.6.4. shall be measured from the time the Contractor receives all information deemed reasonably necessary and sufficient to render a decision. In no event, however, shall the Contractor render a decision on a request for prior authorization more than twenty (20) days following the request.

D.7. Peer Review Requirements

D.7.1. The Contractor shall conduct peer reviews on any request for authorization that fails to meet authorization criteria in the judgment of the first level review clinician. A physician will conduct all peer reviews.

D.7.2. The provider shall designate the appropriate individual to represent the provider in the peer review process. The provider shall not be required to submit additional written documentation for this peer review.

D.7.3. The Contractor shall base its determination on peer desk review if the provider requests not to participate in a peer review. Except as provided in D.7.3, the Contractor shall schedule the peer review to occur within two (2) business days of the request for authorization unless the provider peer is unavailable, in which case the Contractor may make the determination based on a peer desk review.

D.7.4. The Contractor shall complete such decisions within the timeframes set forth in Subsection D.6 above. The Contractor shall offer an appointment to providers for

peer review to take place within two days of the completion of the first line care manager review for inpatient levels of care.

D.8. Out-of-State Providers

D.8.1. The Contractor shall allow an out-of-state provider who is not enrolled in the Connecticut Medical Assistance Program Provider Network to submit an authorization request to the Contractor when an eligible member is temporarily out-of-state and requires services. This allowance shall apply to clients who are out of state and does not apply to in-state providers or to members located within ten (10) miles outside of the state line as these members can access services from a provider already enrolled in the Connecticut Medical Assistance Program ("CMAP") Provider Network.

D.8.2. The Contractor shall render a decision in accordance with the timeframes set forth in the timeliness standards set forth in Sections D6 and D7 of this RFP. For authorization requests meeting these parameters, the Contractor shall:

D.8.2.1. Review the provider's credentials to determine whether the provider is eligible to enroll.

D.8.2.2. Review the request for services for medical necessity.

D.8.2.2.1. If deemed medically necessary, provide an authorization number to the non-enrolled out-of-state provider seeking to authorize services to an eligible member. This authorization cannot be included in the transmission of authorizations to the Department's MMIS contractor until the provider is enrolled but it shall be transmitted within 15 business days of receipt of a provider file that indicates that the provider is enrolled.

D.8.2.2.2. Provide provider enrollment instructions to non-enrolled out-of-state providers.

D.9. Written Notice

D.9.1. The Contractor shall send written notice to providers regarding all decisions made on their requests for service authorization, registration or continued stay. Such notices shall be sent within three (3) business days of the decision.

D.9.2. All notices must reference the provider's CMAP identification number when the provider has enrolled with CMAP. The written notice of a favorable decision must include an authorization number and statement notifying the provider that although the services have been authorized, the authorization does not confer a guarantee of payment.

D.9.3. The Contractor shall send to members written notice in English, or in Spanish for members for whom Spanish is the primary language, regarding service authorization denials, in accordance with the "Notice of Action, Denials, Appeals

and Administrative Hearings" Section of this RFP.

D.10. Web-Based Automation

D.10.1. The Contractor shall establish a secure automated, web-based system to receive, screen, and respond to service registration and authorization requests for services outlined in Exhibit C, Proposed UM Scope and Thresholds. The web-based system must:

D.10.1.1. Verify the eligibility of the intended Member for health services.

D.10.1.2. Issue an immediate on-screen notice that informs the requesting provider that a clinical review and authorization are required and that the provider must contact the provider line to complete the review with a clinician if any of the following are true:

D.10.1.2.1. The provider is registering a member for a service for which an authorization already exists;

D.10.1.2.2. The provider is registering a member for a service that cannot be simultaneously authorized with an existing service without a clinical review; or

D.10.1.2.3. The provider is registering a member for a service that otherwise requires clinical review.

D.10.1.3. Provide a real-time electronic authorization response including provider number, service location, authorization number, units authorized, begin and end dates, service class and billable codes, as well as notify providers when the information submitted for an authorization of service is incomplete and that describes what required information is missing.

D.10.1.4. Permit providers to obtain information regarding the status of services for which they have been authorized, including units authorized, begin and end dates, and units remaining, through a look-up function in the automated web-based system.

D.10.2. The Contractor shall provide to the Department secure access to the Contractor's web-based application.

D.11. Staff Credentials, Training and Monitoring

D.11.1. The Contractor shall utilize clinicians with the following relevant training and experience to conduct reviews for requests for medical services. The Contractor shall ensure that the clinicians:

D.11.1.1. Are individually licensed health care professionals.

D.11.1.2. Conducting reviews shall have, at a minimum, five (5) years direct

service experience in the delivery of medical services.

D.11.1.3. Have licensure in the State of Connecticut.

D.11.1.4. Participate, at a minimum, in a combined total of fifty (50) hours of annual training in continuing education certified by an appropriate certifying body.

D.11.1.5. Have experience and a demonstrated competency with performing UM.

D.11.2. The Contractor may use clinical assistants or liaisons to gather and prepare materials to support review by licensed clinicians.

D.11.3. The Contractor shall conduct, no less frequently than quarterly, reviews of authorizations issued by each staff member. The reviews shall monitor the timeliness, completeness, and consistency with UM criteria of the authorizations and shall be reported by the Contractor to the Department annually. The Contractor shall:

D.11.3.1. Require individual staff performing at less than 90% proficiency in any UM criteria during any month, as demonstrated through the review, to receive additional coaching and be monitored monthly, until they show consistent (i.e. at least two (2) months in a row) proficiency at the 90% level.

D.11.3.2. Require the removal of the staff person from UM responsibilities if the monthly reviews of that staff person demonstrate three (3) consecutive months of audits at below 90% proficiency.

D.11.4. The Contractor shall throughout the term of the contract resulting from this RFP, retain at least one full-time Medical Director 100% of whose time is dedicated to the fulfillment of the Contractor's obligations under the contract resulting from this RFP and to the clinical supervision of all of the Contractor's clinical management functions. The Medical Director must be on-site in the Connecticut Service Center. The Contractor shall require and ensure that the Medical Director is a physician, board certified or eligible in their clinical specialty with experience in managed care and the clinical treatment and management of individual clients enrolled in a public sector health care program. The Contractor may split this position between part-time physicians subject to the Department's review and approval. The Contractor must demonstrate and certify to the Department that the split position retains full time equivalency and adequacy of coverage for the population.

D.11.5. The Contractor shall, throughout the term of the contract resulting from this RFP, retain or contract with specific specialists, including but not limited to a geriatrician, physiatrist, general pediatrician, general internist or family physician, if the Contractor's Medical Director does not have this experience. These specialists shall have experience in the clinical treatment and management of individual clients enrolled in a public sector health care program.

D.12. Records

D.12.1. The Contractor shall, at a minimum, include the following data elements in the service authorization process:

D.12.1.1. Member name, EMS issued ID number, race, ethnicity, age, date of birth, gender and address;

D.12.1.2. Date and time the request for authorization or registration was made;

D.12.1.3. Type of good or service, including level of care and units of service/length of stay requested;

D.12.1.4. Type of good or service and level of care authorized, denied or partially denied, including diagnosis and procedure codes;

D.12.1.5. Start and stop dates of authorization;

D.12.1.6. Number of visits, days, units of service, and/or dollar limit (as appropriate) authorized;

D.12.1.7. Reason for referral or admission (including diagnostic information);

D.12.1.8. Reason for denial, reported according to the specific section of the definition of medical necessity used to justify the denial;

D.12.1.9. Authorized provider name and number (or contact information);

D.12.1.10. Location where service will be provided (if provider has more than one location);

D.12.1.11. Authorization number, date and time;

D.12.1.12. The name of the individual and their credentials that authorized or denied the requested service;

D.12.1.13. The tracking status of any requested documentation;

D.12.1.14. The program under which coverage is provided for each service request; which will in turn indicate whether or not an NOA or denial is required to be sent for adverse decision;

D.12.1.15. An indicator for when a member is receiving ICM or, by virtue of obtaining the requested service, has triggered an ICM threshold;

D.12.1.16. An indicator of court involvement and/or mandated activity by type related to the service authorization in question; and

D.12.1.17. An indicator for individuals eligible for ICM, which would include an

ICM start and end date.

D.12.1.18. Additional elements may be requested in order to meet MMIS requirements.

D.12.2. The Contractor shall maintain internal records of all UM decisions, member clinical status, and service utilization in a manner consistent with company policy, as approved by the Department.

D.12.3. The Contractor shall maintain a UM system that has the capacity to enter and maintain text for the following:

D.12.3.1. The member's presenting symptoms, history, other services tried;

D.12.3.2. Clinical review notes;

D.12.3.3. Any inpatient admission request information for which an admission is not approved;

D.12.3.4. Notes from discussions with other medical professionals employed by or contracted by the Contractor;

D.12.3.5. Citation of review criteria for approval or denial; and

D.12.3.6. Any other information or call tracking related to a member's care including indication of need for coordination with behavioral health or Medicaid Waiver programs.

D.13. Inpatient Census Report

D.13.1. The Department shall require all inpatient general and chronic disease hospitals to notify the ASO of all inpatient admissions of individuals dually eligible for Medicare and Medicaid.

D.13.2. The Contractor shall develop and present to the Department for review and approval by January 1 2012, a process to provide the primary care provider, medical home, or health home with a daily census report as indicated in Exhibit E, which shall include all individuals admitted to general hospitals and chronic disease hospitals. The Department shall accept or reject the process within 30 days of the receipt of the proposed process.

D.13.3. Once approved by the Department the Contractor shall implement the process and maintain the same throughout the term of the contract unless revised with the approval of the Department

D.13.4. The Contractor will notify the appropriate waiver staff members of all inpatient admissions to general acute and chronic disease hospitals of individuals who are enrolled in waiver programs. Responsibility for ICM for these individuals may be transferred to the waiver at the discretion of the waiver staff members

D.14. Transitional Care Management

D.14.1. The Contractor shall provide transitional care management for members with authorized acute inpatient care and chronic disease hospital care, including individuals about whom the Contractor received notification, but who are dual eligible and thus whose inpatient care did not require authorization.

D.14.2. Transitional care management shall be conducted as a person-centered, interdisciplinary process that includes member and family participation in all phases of the planning process. Participation activities shall include but not be limited to:

D.14.2.1. Discussion of anticipated discharge plans with inpatient providers within two days of admission;

D.14.2.2. Ongoing collaboration between the member, family and the interdisciplinary care team, including the provision of verbal and written information on the range of services and available options in the member's community.

D.14.2.3. Identification of the cause(s) where the discharge may be impeded or impacted by the need for housing, foster care or living arrangement. Confirm that DCF, DDS, DMHAS, or waiver case management staff as appropriate, are notified regarding the discharge.

D.14.2.4. Assisting providers as necessary with discharge planning and oversee the coordination of care and medication reconciliation with the aftercare facility or provider(s).

D.14.2.5. Obtaining complete information describing the aftercare plan including providers' names, dates of follow-up visits with PCP and specialists, referrals to case management, if necessary, medication regimen, home health care and transportation arrangements.

D.14.2.6. Reviewing plans for completeness prior to discharge especially to assure that initial visits for essential services have been arranged prior to discharge and to review whether the provider has discussed the plan with the member or legal guardian and provided him or her with a written copy.

D.14.2.7. Transitional coordination shall ensure that necessary member education regarding the care plan has occurred post-discharge, and include condition specific self-management education. When necessary for the success of the aftercare plan, the Contractor will be expected to meet with the member to educate them about their care plan.

D.14.3. The Contractor shall monitor follow up care for members discharged from inpatient care by:

D.14.3.1. Contacting the lead clinical provider as designated in the discharge plan within seven (7) days after discharge to ensure that the members have

obtained follow-up care. This shall include, but not be limited to, arrangements for medication, home health care, durable medical equipment, and skilled nursing facility, as needed.

D.14.3.2. Offering assistance with appointment scheduling for members who have not obtained follow-up care.

D.14.3.3. Identifying reasons for unsuccessful follow-up care and communicating this to the Contractor's Quality Management unit.

D.14.3.4. Identifying inpatients who would qualify for Intensive Care Management (using the criteria in Section E below) and referring them for enrollment in ICM.

D.14.3.5. The Contractor shall coordinate with the appropriate waiver personnel to augment any necessary medical or disease management identified as the individual transitions from a skilled nursing facility to a community setting or placement.

D.15. The Bidder Shall:

D.15.1. Provide a written program description outlining the UM program model, methods, structure and accountability that would be implemented for the resultant contract.

D.15.1.1. The description shall include the Contractor's recommendation for services for which to require prior authorization, proposed standards to determine which individuals require transition planning (or alternatively, which do not) and strategies to enlist the provider community's cooperation with and support of its utilization management program. This requirement is in addition to the requirement for full organizational disclosure located in Part Three of this RFP.

D.15.1.2. Include a proposed organizational chart and flow chart consistent with the program description.

D.15.2. Provide a full description of the UM system capabilities including screen prints to illustrate how the system prompts reviewers to use and apply clinical criteria, to document decisions and the basis for the decisions and to issue required notices.

D.15.3. Propose an organizational chart, flow chart and written program description outlining the UM program structure and accountability that would be implemented for the resultant contract. This requirement is in addition to the requirement for full organizational disclosure located in Part Three of this RFP.

D.15.4. Comment on Exhibit C - UM Scope and Thresholds. Indicate whether requiring prior authorization and continued care review is recommended for the identified service types and, if not, describe the modifications recommended. In

addition, please propose frequency of review criteria for each service type and recommended usual units/days authorized.

D.15.5. Describe the level of care guidelines or medical necessity criteria that are used for utilization review.

D.15.5.1. Discuss how these guidelines are updated.

D.15.5.2. Describe any other databases or information resources that will be used to support utilization review decisions.

D.15.5.3. Describe how utilization review will be based on the latest medical evidence and allow the rigorous but appropriate application of the criteria contained in the Department's medical necessity definition.

D.15.6. Propose a "bypass" program to enable high performing providers to fulfill prior authorization requirements through the notification process. The Bidder shall at a minimum describe the process that would be used to identify providers who would be eligible for participation, the percentage of providers using it in their existing contracts, and the procedures for conducting random retrospective audits (data and/or on-site) to ensure continued qualification as a high performing provider. Include a methodology to monitor the success of the overall program, and the performance of those providers put on "by-pass."

D.15.7. Propose an approach to facilitating and enhancing the discharge planning process and the provision of transitional care management for individuals admitted to inpatient facilities, to include but not be limited to proactive plans of care and follow-up, strategies for communication, medication information and reconciliation, and processes for transitions or "hand-offs" (across providers and settings.

D.15.8. Propose an approach to monitor transitional care management, including tracking of hospital readmissions, and coordination of transitions of care for individuals receiving waiver services with the appropriate waiver personnel.

E. INTENSIVE CARE MANAGEMENT

E.1. General Provisions:

E.1.1. Intensive Care Management is the organization of patient care activities for individuals with significant clinical conditions that severely impact their daily lives. These members may have one or more chronic conditions with or without co-occurring behavioral health conditions, or nonclinical circumstances which prevent them from effectively utilizing medically necessary care.

E.1.2. The purpose of ICM is to facilitate the appropriate delivery of health care services by:

E.1.2.1. Organizing the care using a person-centered, multidisciplinary primary

care and specialty practice team,

E.1.2.2. Recruiting the personnel and other resources required to support the individual and to address their needs,

E.1.2.3. Exchanging information among participants responsible for different aspects of the care, including the member, and

E.1.2.4. Delineating and informing participants about each others' roles in the person's care and the available resources to fulfill the care plan.

E.1.3. Throughout the term of this contract, the Contractor will be expected to use health data analytics to facilitate the identification of members who require or who are at high risk of requiring intensive care management. At a minimum, this shall include

E.1.3.1. identification of members with chronic conditions with or without co-occurring behavioral health conditions, acute conditions such as high risk pregnancies or severe trauma; or circumstances such as homelessness, domestic violence, or involvement with the Department of Children and Families, or others who utilize or are at risk of utilizing excessive amounts of health resources.

E.1.4. The Contractor will be required to submit a report, using a format and frequency to be determined by the Department, in consultation with the Contractor, which describes the Contractor's Intensive Care Management activities. At a minimum, the report will require patient demographics, diagnoses, medications, other special needs or services (DME, home nursing), placement (home, nursing facility), number and types of care management services or interventions (such as specialist referrals, arrangement of transportation services, etc.) and whether the member accepted or refused ICM services. If a member is discharged from ICM, the reason for their discharge should also be reported.

E.1.5. Preventive care remains the cornerstone of all care, most especially for those with chronic illnesses. Not only does routine preventive care remain important to maintain the health status of all members regardless of their clinical circumstances, prevention is a vital element of the care of those with chronic illnesses to ensure the progression of their illnesses is minimized and that they are not further victimized by other preventable diseases. Although the population bears a significant chronic disease burden, it does so in the context of poverty and cultural diversity, which add to the challenge of caring for one's chronic disease in the face of other adversity and unmet daily needs. It is expected that the Contractor's ICM program will include staff members whose expertise include the care of those from diverse cultural and socioeconomic backgrounds.

E.1.6. The ASO is expected to provide ICM at the ASO's Connecticut service center, however, regional deployment of Intensive Care Managers in the field may help build local collaborative relationships and improve effectiveness.

E.1.7. As the ASO and the Department recruit and certify Patient-Centered Medical

Homes (PCMH), the ASO will have less of a role in coordinating care for individuals assigned to the PCMH practices. In many cases, it is expected that the ASO will identify high risk individuals and provide linkages to the PCMH. PCMH practices that meet the special requirements for serving as a Health Home will be expected to provide all necessary ICM (or the equivalent) for members attributed to them. Here as well, the ASO will be expected to identify high risk members and link these members to their ICM counterparts employed by the Health Home. Although the Department envisions a migration of care coordination and ICM functions to local PCMH/HH practices, clinics and service delivery systems, there may be an ongoing role for the ASO with respect to these functions. These ASO functions will continue to be necessary for individuals who are not assigned to a PCMH/HH. In addition, it is possible that the ASO could establish local hubs that support multiple small group practices too small to establish dedicated resources on site.

E.2. Intensive Care Management Program Development and Approval

E.2.1. The Contractor shall submit their proposed ICM Program including a program description, policies, procedures, workflows, and qualifying criteria for children, adolescents and adults to the Department for its review and approval on or before December 1, 2011.

E.2.2. The Department shall review and comment, approve or reject the submission. Once approved by the Department, the Contractor shall implement the approved ICM Program to be effective as of the implementation date and shall utilize the approved criteria unless and until revisions to the qualifying criteria are approved by the Department.

E.2.3. The Contractor shall propose to the Department modifications to the Program including qualifying criteria at least annually and no later than July 1st of each subsequent year of the contract.

E.2.4. The Contractor shall establish an ICM unit with dedicated ICM staff to provide ICM services to members effective on the implementation date and shall identify members who meet the criteria for ICM in accordance with the approved ICM Program.

E.2.5. The Contractor's ICM staff shall receive training in person-centered care planning.

E.2.6. The Contractor's ICM Program shall focus on members for whom the Contractor determines that the routine care management process in Section D is inadequate.

E.2.7. The intensive care managers shall convene a multi-disciplinary care team made up of clinicians, care providers, and the member or the member's designee, to develop a personal plan of care in order to improve individual outcomes.

E.2.8. In the first year, the contractor's ICM Program shall include the following special populations in addition to those populations identified through the Contractor's

predicting modeling and health risk stratification methods:

E.2.8.1. Pregnancies at high risk of adverse outcomes,

E.2.8.2. Newborns at high risk of poor developmental, behavioral or medical outcomes, and.

E.2.8.3. Clients with untreated conditions causing chronic pain for which they are at risk of overusing addictive pain medications.

E.3. Local Area Assignment

E.3.1. Intensive care managers shall be designated to geographic areas, allowing for cross-coverage as needed.

E.3.2. The intensive care managers shall establish a local presence and build collaborative relationships with providers.

E.4. Reporting

E.4.1. The Contractor shall provide a report as described in Exhibit E - Reporting Matrix of members who have been identified by the Contractor for ICM to the Department.

E.4.2. The Contractor's ICM unit shall also prepare and submit a quarterly summary to the Quality Management Department and the Department. The summary shall identify the following:

E.4.2.1. Coordination and quality issues by provider and geographic area (see Exhibit E);

E.4.2.2. New or promising coordination and care delivery models that have been effectively used in one or more areas of the state to resolve care problems;

E.4.2.3. Recommendations to resolve issues identified in E.6.2.1.

E.5. The Bidder Shall:

E.5.1. Propose an ICM program plan that meets the above requirements. The plan should include but not be limited to:

E.5.1.1. Organizational structure with reporting and supervisory relationships.

E.5.1.2. ICM staff credentials and orientation and training procedures

E.5.1.3. A description of proposed data analytics for population health management and/or health risk stratification that support intensive care management. The detailed narrative should communicate the uniqueness of the bidder's capabilities in this area.

E.5.1.4. ICM process including identification of members requiring ICM,

enrollment processes, intervention strategies for ICM, use of a care plan, coordination with primary care and other providers, and local services and supports.

E.5.1.5. A process for individuals to opt out of the ICM process.

E.5.1.6. A strategy for identifying individuals excessively seeking care in inappropriate care settings and developing mechanisms to facilitate care in more appropriate settings.

E.5.1.7. A strategy for communication with the member, service and support providers, local social and community service agencies, and the member's family and key supports.

E.5.1.8. The role of the bidder's information systems in supporting the ICM process and fidelity to the proposed ICM model.

E.5.1.9. Plan for coordination, communication and integration of the work of the ICM staff with the local service system such as by establishing local or regional outstations and building collaborative relationships with providers,

E.5.1.10. Describe any analyses that the bidder has undertaken using claims or encounter data to develop care management or ICM priorities. Propose a monthly ICM program capacity (e.g., individuals served per month).

E.5.1.10.1. What conclusions did the bidder reach based on its analyses?

E.5.1.10.2. What do the data suggest would be the most important areas to focus ICM resources during the first two years?

E.5.1.10.3. Based on this analysis, what is the bidder proposing for monthly ICM program capacity (e.g., individuals served per month).

E.5.1.11. Describe differences in the approach that would be used for ICM for members who are attributed to medical and health homes.

E.5.1.12. Provide an example of ICM care plans currently in use and describe the process utilized to capture data related to care plans.

E.5.1.13. Describe the process for ICM unit communication with other units within the ASO such as the UM, QM, Provider Network and Provider Relations Department.

E.5.1.14. Describe the process by which the ICM unit will communicate and coordinate care with the Behavioral Health Partnership and the Dental Health Partnership.

E.5.1.14.1. Include a proposal to establish lead ICM responsibility for individuals with serious medical and behavioral health co-morbidities,

E.5.1.15. Describe how Contractor's ICM resources might be modified or reduced in coordination with the emergence of PCMH/HH providers.

E.5.1.15.1. Detail considerations with respect to this transition.

E.5.1.16. Provide a description of how the bidder's proposed ICM program takes into consideration cultural diversity and poverty.

E.5.1.16.1. Include a description of its record of collaborative work with community-based organizations, other government and non-government agencies, and community-based advocacy groups to create innovative approaches to health care delivery in the context of poverty and cultural diversity.

F. PRIMARY CARE PROVIDER ASSIGNMENT

F.1. General Provisions

F.1.1. Primary Care is the basis of high quality and affordable health care. Adequate access to primary care is associated with greater use of preventive care and in improvements in patient satisfaction, patient outcomes and health service value.

F.2. Requirements of the Contractor.

F.2.1. The Contractor shall implement procedures to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person formally designated as primarily responsible for coordinating the health care services furnished to the member.

F.2.2. The Contractor shall provide members with the opportunity to select a PCP. If the member fails to select a PCP within thirty days from the date of enrollment the Contractor shall assign a member to a PCP within two weeks from the thirtieth day of enrollment as follows:

F.2.2.1. The Contractor shall review the member's office visits (if any) over the previous 24 months and shall base the assignment on the most recent or most frequent visit.

F.2.2.2. If a provider can be identified, but not a specific PCP, the Contractor shall contact the provider and request that the provider suggest a specific PCP assignment.

F.2.2.3. If neither a provider nor a PCP can be identified, the Contractor shall assign the member to the nearest PCP with available capacity or assign by other method mutually agreeable to the Contractor and the Department.

F.2.3. The Contractor shall issue "welcome packets" and conduct outreach calls following Member's enrollment in the ASO and shall encourage members to select

a PCP.

F.2.4. The Contractor shall clearly explain to members that if they do not select a PCP within thirty days of enrollment, the ASO will assign such members to a PCP. The assignment shall be appropriate to the member's age, gender and residence.

F.2.5. The Contractor shall ensure that all materials and contacts with members are linguistically and culturally appropriate.

F.2.6. The Contractor shall allow members to change PCPs at any time.

F.2.7. The Contractor shall report quarterly on each PCP's panel size, group practice and hospital affiliations in a format specified by the Department.

F.2.7.1. In the event that a PCP has more than 1,200 members, the Contractor will take appropriate action to ensure that patient access to the PCP is ensured.

F.2.8. The Contractor shall track each member's use of primary care services.

F.2.8.1. In the event that a member does not regularly receive primary care services from the PCP or the PCP's group other than visits to school based health clinics, the Contractor shall contact the member and offer to assist the Member in selecting a PCP.

F.3. The Bidder Shall

F.3.1. Propose a PCP Assignment plan that meets all of the above requirements.

G. PERSON-CENTERED MEDICAL HOME AND HEALTH HOME ATTRIBUTION

G.1. General Provisions

G.1.1. PCMH is an approach to providing accessible, continuous, coordinated and comprehensive primary care that facilitates partnerships between individual members and their personal providers, and when appropriate, the member's family. The focus in this person-centered approach is on the person who has a disease or illness, and how the disease or illness impacts their life, rather than on the illness or disease itself. If implemented successfully, this approach results in better informed who are better able to participate in their care, ultimately leading to better clinical outcomes.

G.1.2. The provision of medical homes may allow better access to health care, increase satisfaction with care, and improve health. The provider receives supplementary payments for coordinating patient care. The provider is required by terms of the agreement to provide this coordination and is encouraged to improve practice infrastructure in order to qualify as a medical home. Health Homes (HH) are PCMH providers who meet higher standards for care coordination and function as a health

service team.

G.1.3. PCMH/HH providers will be designated by the Department beginning in January 2012. For the purpose of this Request for Proposal, the bidder should assume that 15 PCMH/HH providers will be designated during year one of the initiative. This number will be refined pending the conduct of a readiness review. The method proposed below for PCMH/HH assignment is not final pending review with the Medicaid Care Management Oversight Council.

G.2. Requirements of the Contractor.

G.2.1. The Contractor shall implement procedures to coordinate the attribution of members to PCMH/HH providers.

G.2.1.1. Members shall be automatically attributed by the Contractor to a PCMH/HH if the assigned PCP is a member of a PCMH/HH practice or clinic.

G.2.1.2. Once attributed, the Contractor will be required to provide information to the member notifying them of the attribution and explaining the PCMH/HH program.

G.2.1.3. The member must be instructed how he can select a different PCMH/HH provider if one is available in his area and if he so prefers.

G.2.1.4. The member must also be instructed regarding his right to opt out of the PCMH/HH program if he chooses not to be attributed to a PCMH/HH provider.

G.2.1.5. The Contractor shall notify the Department and the PCMH/HH provider of all attributions. The notification will trigger the initiation of PCMH/HH payments to the provider within 60 days of notification.

G.2.1.6. The Contractor shall allow members to change PCMH/HH at any time, effective on the first day of the month following notification to the Contractor.

G.2.1.7. The Contractor shall notify the initial PCMH/HH, the newly selected PCMH/HH and the member of any change in attribution. If the member is active in ICM, the ICM will notify all participants in the member's care team of the change in attribution.

G.3. The Bidder Shall

G.3.1. Propose a PCMH/HH attribution plan that meets all of the above requirements.

H. EARLY AND PERIODIC, SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) SERVICES

H.1. Requirements

H.1.1. The Contractor will be responsible for ensuring that all Medicaid-eligible individuals under twenty-one (21) years of age receive EPSDT services.

H.1.2. EPSDT services consist of comprehensive child health care services, including all medically necessary prevention, screening, diagnosis and treatment services listed in Section 1905 (r) of the Social Security Act. These services include:

H.1.2.1. Informing: Written and oral methods designed to effectively inform all EPSDT eligible clients about the program.

H.1.2.2. This includes the provision of information about the benefits of preventive health care, the services available under EPSDT, including transportation and scheduling assistance.

H.1.2.3. Special provision must be made for clients and their families who: have limited English proficiency or are hearing or vision impaired.

H.1.2.4. Oral informing techniques may include face-to-face contact, public service announcements, community campaigns and other media.

H.1.3. EPSDT Case Management Services: Services such as making and facilitating referrals and development and coordination of a plan of services that will assist Members under twenty-one (21) years of age in gaining access to needed medical, social, educational, and other services.

H.1.4. EPSDT Diagnostic and Treatment Services: All health care, diagnostic services, and treatment necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by an interperiodic or periodic EPSDT screening examination.

H.1.5. EPSDT Screening Services: Comprehensive, periodic health examinations for Members under the age of twenty-one (21) provided in accordance with the requirements of the federal Medicaid statute at 42 U.S.C. § 1396d(r)(1).EPSDT Special Services: As required by 42 U.S.C. § 1396(r)(5), other health care, diagnostic services, preventive services, rehabilitative services, treatment, or other measures described in 42 U.S.C. 1396d(a), that are not otherwise covered under the Connecticut Medicaid Program and that are medically necessary.

H.2. Access to Services Recommended Pursuant to an EPSDT Exam

H.2.1. The Contractor shall authorize all medically necessary medical services that may be recommended or ordered pursuant to an EPSDT periodic or interperiodic examination including medically necessary services that are not otherwise covered under the Connecticut Medicaid Program.

H.2.2. The Contractor shall facilitate access to medically necessary health services recommended pursuant to an EPSDT examination when requested by the member

or designated representative or when the Contractor otherwise determines that it is necessary and appropriate as follows:

H.2.2.1. Provide families with information about how to obtain health care services for their children and where these services can be obtained.

H.2.2.2. Assist families with scheduling appointments with health service providers.

H.2.2.3. Assist with transportation for children and their families to appointments for health services. Assistance includes providing the member and/or their family with the information necessary to arrange for transportation to the appointments through the Department's transportation services broker(s) and/or providing assistance in coordinating such transportation if the member and/or their family encounters barriers.

H.2.2.4. Arrange for the provision of the medically necessary health services that are not covered under the Connecticut Medicaid Program by working with the Department to implement special provider service agreements.

H.3. The Bidder shall:

H.3.1. Describe how it would implement procedures to effectively inform all EPSDT clients of the services available under EPSDT. This shall include a detailed description of the processes for informing members in writing, or orally, or a combination thereof.

H.3.2. Describe how it will document and record proof of written informing for each client, including documentation of materials sent, date sent and to whom the materials were sent.

H.3.3. Describe its processes for ensuring that EPSDT clients are generally informed of services within 60 days of the client's eligibility determination, and for clients who have not used EPSDT services, annually thereafter

H.3.4. Describe its methods for ensuring that EPSDT clients with limited English proficiency, visual and hearing impairments will be informed of EPSDT services.

H.3.5. Describe its processes for identifying Children with Special Health Care Needs to outreach for EPSDT services.

H.3.6. Describe its processes and procedures for providing assistance with non-emergency medical transportation to EPSDT clients.

H.3.7. Describe its process for providing scheduling assistance for EPSDT services.

H.3.8. Describe policies and procedures to maintain and improve upon current EPSDT participation and screening ratios for all age groups, including strategies to improve

screening rates for adolescents and other hard to reach populations.

I. REQUIREMENTS FOR OTHER PROGRAMS AND POPULATIONS

I.1. Children's Health Insurance Plan (CHIP) Requirements - The Contractor shall ensure that the families of all HUSKY B enrolled individuals receive benefit information about CHIP services, shall inform families with Children and Youth with Special Health Care Needs (whose family income is within Bands 1 and 2) about the HUSKY Plus Physical benefit package and coordinate administration of this benefit with HUSKY B Plus Physical benefit subcontractor, and shall facilitate administration of the co-insurance benefit with the Department or its agent.

I.1.1. The Contractor shall inform the families of all CHIP eligible clients about the program using written and oral methods, including:

I.1.1.1. Providing families with information about how to obtain health care services for their children and where these services can be obtained.

I.1.1.2. Assisting families with scheduling appointments with health service providers.

I.1.2. The Contractor shall inform the families of all eligible CHIP clients with Children and Youth with Special Health Care Needs about the HUSKY Plus Physical Program about the program using written and oral methods, including:

I.1.2.1. Providing families with information about eligibility requirements;

I.1.2.2. Providing families with information about how to obtain health care services for their children and where these services can be obtained; and

I.1.2.3. Assisting families with scheduling appointments with health service providers.

I.1.2.4. Special provision must be made for clients and their families who have limited English proficiency, or are hearing or vision impaired. Oral informing techniques may include face-to-face contact, public service announcements, community campaigns and other media.

I.1.3. Coordination of CHIP Benefits

I.1.3.1. The Contractor shall work to coordinate benefits with the appropriate Department agent.

I.1.3.2. The Contractor shall collect and transfer data on cost sharing with the Department and/or its agent.

I.1.3.3. The Contractor shall coordinate care for Children and Youth with Special Health Care Needs with the subcontractor managing this benefit.

I.1.4. The Bidder Shall:

I.1.4.1. Describe how it would implement procedures to effectively inform all CHIP clients of the services available under CHIP.

I.1.4.2. Describe how it will document and record proof of written informing for each client, including documentation of materials sent, date sent and to whom the materials were sent.

I.1.4.3. Describe its methods for ensuring that CHIP clients with limited English proficiency or visual and hearing impairments will be informed of CHIP services.

I.1.4.4. Describe its processes for ensuring that CHIP clients are generally informed of services within 60 days of the client's eligibility determination, and for clients who have not used CHIP services, annually thereafter.

I.1.4.5. Describe its process for providing scheduling assistance for CHIP services.

I.1.4.6. Describe its processes for coordinating benefits across all entities administering the CHIP benefit.

J. PRENATAL CARE

J.1. In order to promote healthy birth outcomes, the Contractor shall:

J.1.1. Identify pregnant Members as early as possible in the pregnancy;

J.1.2. Conduct prenatal risk assessments in order to identify high risk pregnant Members, arrange for specialized prenatal care and support services tailored to risk status, and begin care coordination that will continue throughout the pregnancy and early postpartum weeks;

J.1.3. Refer pregnant Members to the WIC program;

J.1.4. Offer case management services to assist pregnant Members with obtaining prenatal care appointments, transportation, WIC, and other support services as necessary;

J.1.5. Offer prenatal health education materials and/or programs to pregnant Members aimed at promoting healthy birth outcomes;

J.1.6. Offer HIV and other sexually-transmitted disease (STD) testing and counseling and all appropriate treatment to pregnant Members;

J.1.7. Refer pregnant Members who are actively abusing drugs or alcohol to CT BHP ASO; and

J.1.8. Educate Members who are new mothers about the importance of the postpartum

visit and well-baby care.

J.2. The ASO shall comply with requirements of the Newborns' and Mothers' Health Protection Act of 1996 regarding requirements for minimum hospital stays for mothers and newborns in accordance with 45 CFR §§ 146.130 and 148.170.

K. COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH CARE

K.1. Overview: Except as otherwise identified in this section and this RFP, care management for behavioral health services for all members will be managed by the behavioral health ASO.

K.1.1. The Contractor shall promote coordination of physical health and behavioral health care. The Contractor will be responsible for coordination with the Behavioral Health Partnership. The Contractor shall promote communication between primary care providers (PCPs) and behavioral health providers and shall support primary care based management of psychiatric medications as medically appropriate.

K.1.2. For individuals who access health services and who also have special behavioral health care needs, the Contractor shall help ensure that services are coordinated, that duplication is eliminated, and that lead management is established in cases where medical and behavioral needs are serious or complex. Coordination of physical and behavioral health care shall be included in the Contractor's clinical management program.

K.1.3. If there is a conflict between the Contractor and the BHP regarding whether a member's medical or behavioral health condition is primary, the Contractor's medical director shall work with the BHP's medical director to reach a timely and mutually agreeable resolution. If the two entities are not able to reach a resolution, the Department will make a binding determination. Issues related to whether a Member's medical or behavioral health condition is primary must not delay timely medical necessity determinations. In these circumstances, the Contractor shall render a determination within the standard timeframe required under the contract resulting from this RFP and its policies and procedures. The Contractor shall be responsible for primary care and other services provided by primary care providers in hospitals regardless of diagnosis.

K.1.4. The Contractor shall be responsible for primary care and other services provided by primary care solo and group practitioners and medical clinics not affiliated with a hospital, regardless of diagnosis with the following exception. Contractor shall not be responsible for managing behavioral health evaluation and treatment services provided in these settings and billed under CPT codes 90801-90806, 90853, 90846, 90847 and 90862, when the member has a primary behavioral health diagnosis and the services are provided by a licensed behavioral health professional.

K.2. Behavioral Health-related Responsibilities of the ASO

K.2.1. The Contractor shall be responsible for the following behavioral health related activities provided in primary care settings:

K.2.1.1. Behavioral health related prevention and anticipatory guidance;

K.2.1.2. Screening for behavioral health disorders;

K.2.1.3. Treatment of behavioral health disorders that the PCP concludes can be safely and appropriately treated in a primary care setting; and

K.2.1.4. Management of psychotropic medications in conjunction with treatment by a non-medical behavioral health specialist, when necessary.

K.2.2. The Department will require that the Contractor support the provision of medication management by primary care providers for persons with behavioral disorders when such care can be provided safely and appropriately by such providers.

K.2.3. The Department will require the Contractor and the BHP to work together to identify and manage individuals over utilizing emergency department services for complaints not clearly just medical or behavioral in nature, such as frequent complaints of pain and pain-related symptoms.

K.2.4. The Department will require the BHP to collaborate with the Contractor to coordinate services for individuals with both behavioral health and special physical health care needs.

K.2.5. The Department will require that the Contractor assume responsibility for management of home health services when the home health service is for medical diagnoses alone and when the home health services are required for medical and behavioral diagnoses, but the medical diagnosis is primary or the member's medical treatment needs cannot be safely and effectively managed by the psychiatric nurse or aide.

K.2.6. The Contractor shall not be responsible for management of home health services for a member when the member has a diagnosis of autism as one of the first three diagnoses.

K.2.7. The Department will require the Contractor to manage all ancillary services such as laboratory, radiology, and medical equipment, devices and supplies regardless of diagnosis.

K.3. Coordination with CT BHP

K.3.1. The Contractor shall communicate and coordinate with the CT BHP as necessary to ensure the effective coordination of medical and behavioral health for individuals

with both behavioral health and special physical health care needs.

K.3.2. The Contractor shall collaborate with the Department or the BHP to coordinate hospital inpatient services, ED services, laboratory services and other services administered by the BHP.

K.3.3. The Contractor shall provide for all necessary aspects of coordination between the Contractor and the BHP. The details of such coordination shall be set forth by the Contractor in its Behavioral and Physical Health Coordination Program, which shall be submitted to the Department by April 1, 2011 for their review and approval. Specifically the Contractor shall:

K.3.3.1. Contact the appropriate BHP staff when co-management of a member is indicated, such as for persons with special physical health and behavioral health care needs;

K.3.3.2. Respond to inquiries by the BHP regarding the presence of behavioral co-morbidities;

K.3.3.3. Coordinate management activities and services with the BHP when requested by the BHP;

K.3.3.4. Promote and support coordination between medical providers and the behavioral health providers as appropriate; and

K.3.3.5. Participate with the BHP in the development of policies pertaining to coordination between the Contractor and the BHP and shall adhere to such policies as approved by all parties, and as they may be revised from time to time.

K.4. The Bidder Shall

K.4.1. Provide a plan to facilitate the coordination of services for individuals with both behavioral health and physical health care needs. The plan should address:

K.4.1.1. Screening tools for use in primary care and recommendations for their use;

K.4.1.2. Proposed protocols for communication between primary care and behavioral health providers;

K.4.1.3. Identification of medical conditions that require behavioral health screening or assessments; and

K.4.1.4. Recommendations for working with primary care providers whose clients might not normally seek behavioral health services due to generational, ethnic, racial or cultural background to make the behavioral health services available in the primary care setting or to facilitate access

elsewhere.

L. COORDINATION WITH THE DENTAL HEALTH PARTNERSHIP

L.1. Coordination with the DHP

L.1.1. The Contractor shall be responsible for coordination of the health care needs of individuals with the Dental Health Partnership. Except as otherwise identified in this section and this RFP, care management for dental health services for all members will be managed by the dental health ASO and dental services shall be managed by the dental ASO. The Contractor shall:

L.1.1.1. Communicate and coordinate with the DHP as necessary to ensure the effective coordination of medical and dental health benefits;

L.1.1.2. Provide education and guidance to primary care providers with the participation of the Department or the DHP; and

L.1.1.3. In coordination with the Department or the DHP, develop guidelines for primary care based screening and treatment of dental health disorders including indications for referral to a dental health specialist, and procedures for referrals.

L.1.2. The Department will require the DHP to collaborate with the Contractor to coordinate services for individuals with both dental health and special health care needs.

L.2. The Bidder Shall

L.2.1. Provide a plan to facilitate the coordination of services for individuals with both dental health and special physical health care needs. The plan should address:

L.2.1.1. Dental screening practices for use in primary care and recommendations for their use;

L.2.1.2. Proposed protocols for communication between primary care and dental health providers;

L.2.1.3. Identification of medical conditions which ought to trigger special dental health assessments such as pregnancy, as well as dental health concerns or findings which ought to trigger communications with primary care providers; and

L.2.1.4. Recommendations for working with primary care providers whose clients might not normally seek dental health services due to generational, ethnic, racial or cultural background to make the dental health services available in the primary care setting or to facilitate access elsewhere.

M. COORDINATION WITH HOME AND COMMUNITY BASED WAIVER PROGRAMS

M.1. Coordination Agreements

M.1.1. The Contractor shall develop coordination agreements with the Department of Developmental Services and the Department of Mental Health and Addiction Services with respect to the management of services for individuals participating in DDS or DMHAS administered Home and Community Based Waiver (HCBW) programs.

M.2. Other Coordination Responsibilities

M.2.1. The Contractor shall be required to coordinate with HCBW programs administered by the Department including the Acquired Brain Injury waiver program, the Connecticut Home Care Program for Elders, the Personal Care Assistance waiver, the Money Follows the Person project, and any other HCBW waiver programs that may be established by the Department during the period of the contract resulting from this RFP. This shall include, but not be limited to referral of potential clients to these programs in order to maximize community based care.

M.2.2. The Contractor shall be required to track clients who could potentially benefit from waiver participation, but are not able to due to waiting list and capacity. Additional program specific coordination requirements will be determined at a later date.

N. QUALITY MANAGEMENT

N.1. Quality Management (QM) refers to a comprehensive program of quality and cost measurement, quality improvement and quality assurance activities responsive to the Department's objectives. The Department seeks to ensure that all individuals receive appropriate, effective, medically necessary, and cost effective treatment in order to maximize health outcomes. The Contractor will systematically and objectively measure access to care, demand for services, quality of care, and outcomes and analyze utilization data, satisfaction surveys, complaints, and other sources of quality information. This information will support the development of continuous quality improvement strategies by the bidder and by providers that are consistent with the vision and mission of the Department. The primary focus of the bidder's quality management activities will include:

N.1.1. Statewide quality initiatives focused on improving access to well visits, health screens, prenatal care, and care for common illnesses such as diabetes and asthma;

N.1.2. Provider profiling to support quality improvement and pay for performance initiatives;

N.1.3. Performance measurement of PCMH/HH providers, and regional provider consortia such as integrated care organizations with respect to access, quality and cost; and

N.1.4. Statewide performance measurement with respect to access, quality and cost.

N.2. Quality Management Oversight: The Department shall:

N.2.1. Review for approval prior to implementation the Contractor's QM Program description that incorporates its initiatives, strategies, staff time and organization, methodologies for on-going quality assurance, quality improvement, and performance assessment activities;

N.2.2. Require the Contractor to study and evaluate issues that the Department may from time to time identify;

N.2.3. Develop post-implementation quality indicators to monitor performance during the first nine (9) months post-implementation;

N.2.4. Establish annual performance targets as described in the Performance Targets and Withhold section; and

N.2.5. Review for approval all member and provider surveys.

N.3. General Provisions: - The Contractor shall:

N.3.1. No later than January 1, 2012, provide the Department, for its review and approval, a written description of the QM Program including the program structure and processes that explain the accountability of each committee or organizational unit; functional relationships between each committee and organizational unit; policies and procedures and the mechanisms for obtaining input from member and provider groups;

N.3.2. In consultation with the Department, develop performance measures and indicators of a person-centered care system and approach, to be integrated into the QM Program;

N.3.3. Develop mechanisms to track and monitor the post-implementation quality indicators;

N.3.4. Employ a full-time qualified QM Director responsible for the operation and success of the QM program. The QM Director must possess an advanced degree in a field of study relevant to human services and demonstrate at least 5 (five) years of experience in the development and implementation of quality management programs, including participating in audited HEDIS surveys; and

N.3.5. Participate in the Department's QM Committee as requested by the Department to report on all QM activities that are part of the Annual Quality Management Program Plan or to review other issues identified by the Department or the Contractor.

N.4. Annual Quality Management Project Plan and Program Evaluation: - The Contractor

shall:

N.4.1. By March 1, 2012 and annually thereafter, propose to the Department for its review and approval an Annual Quality Management Project Plan that outlines the objectives and scope of planned projects. The Annual Quality Management Project Plan shall describe how the Contractor will conduct:

N.4.1.1. Member satisfaction surveys (program wide and specific to an individual's medical/health home);

N.4.1.2. Provider satisfaction surveys;

N.4.1.3. Measurement of access, quality, care experience and outcomes (program wide and specific to an individual's medical/health home);

N.4.1.4. Clinical Issue Studies; Ongoing Quality Management Activities; and

N.4.1.5. Quality Improvement Initiatives (beginning in year two).

N.4.2. The Contractor shall by April 1, 2012 and annually thereafter, provide a Quality Management Program Evaluation.

N.5. Member Satisfaction Surveys

N.5.1. The Contractor shall conduct annual Member Satisfaction Surveys.

N.5.2. The Contractor shall report the results of such surveys to the Department. The Satisfaction Surveys shall be conducted within the following guidelines:

N.5.2.1. Level of aggregation

N.5.2.1.1. The Contractor shall measure and report to the Department on the satisfaction of members once during each contract year using the CAHPS or similar instrument approved by the Department and using a stratified sample (family coverage, ABD, MLIA) of all members statewide.

N.5.2.1.2. The Contractor shall also measure the satisfaction of members enrolled in or attributed to each medical/health home once during each contract year using the CAHPS or similar instrument approved by the Department.

N.5.2.1.3. The Contractor shall also measure the satisfaction of members who have contacted the service center for assistance. This brief measure will be provided by the Department. The results of this assessment may be the basis for return of a portion of the withhold as established in Exhibit A.

N.5.2.2. Frequency

N.5.2.2.1. The Contractor shall measure the satisfaction of members once during

each contract year.

N.5.2.3. Implementation

N.5.2.3.1. The Contractor shall commence the collection of member satisfaction survey data by March 1, 2012 and annually thereafter.

N.5.2.3.2. The Contractor shall complete the data collection, analysis, interpretation and final reporting to the Department by December 31, 2012 and annually thereafter.

N.5.2.3.3. The Contractor will propose a corrective action plan for the Department's approval, which will be implemented by the Contractor and/or the Department, as appropriate.

N.5.2.4. Methodology:

N.5.2.4.1. The methodology utilized by the bidder shall be based on generally recognized and accepted research methods that ensure an adequate sample size and statistically valid and reliable data collection practices.

N.6. Provider Satisfaction Surveys

N.6.1. The Contractor shall conduct, and report to the Department the results of, an annual provider satisfaction survey using a provider survey instrument approved by the Department. The survey shall, at a minimum, address the provider's satisfaction with the Contractor's services and other administrative services provided by the state or its agents including but not limited to authorization procedures, courtesy and professionalism, network management services, provider appeals, provider education, referral assistance, coordination, claims processing as administered by the Department's MMIS) and overall administrative burden. The first survey will be conducted by October 31, 2012 and annually thereafter.

N.6.2. The Contractor will propose a corrective action plan for the Department's approval, which will be implemented by the Contractor and/or the Department, as appropriate.

N.7. Clinical Issue Studies

N.7.1. The Contractor shall propose to the Department for its approval at least three (3) annual clinical issue studies beginning in year one of the contract.

N.7.2. The Contractor shall during each year of the contract resulting from this RFP,

N.7.2.1. Propose to the Department the scope of the clinical issue studies by March 1;

N.7.2.2. Submit to the Department by June 1st of each calendar year in the contract, or such other date as agreed to by the Department and the

Contractor, for their review and approval, a draft of the study report for each clinical issue study. The study report shall, at a minimum, include recommendations for intervention; and

N.7.2.3. Implement the report recommendations upon approval by the Department.

N.7.3. The Contractor shall use a methodology based on accepted research practices ensuring an adequate sample size and statistically valid and reliable data collection practices.

N.7.4. The Contractor shall use measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate.

N.8. Ongoing Quality Management Activities

N.8.1. The Contractor shall prioritize, monitor, analyze and document problems identified by the UM, ICM, Provider Relations, and Member Services Units, as well as problems identified through the complaints process.

N.8.2. Complaints related to access (lack of access or delays in access) must be categorized at a minimum as to service type and/or specialty (e.g., primary care, cardiology, orthopedics); client age (pediatric, adult, geriatric); and locality.

N.8.3. The Contractor shall propose to the Department recommendations on innovative strategies related to Utilization Management, Care Management and Case Management based on national trends and evidence-based practice.

N.8.4. The Contractor shall investigate and address access and quality of care issues. On-site reviews of quality of care issues conducted by the Contractor must take place during normal business hours with at least 24 hours advance notice.

N.8.5. On behalf of the Department, the Contractor may:

N.8.5.1. Review the quality of care rendered by the provider, including but not limited to chart audits;

N.8.5.2. Conduct visits at the provider's service site;

N.8.5.3. Require corrective action plans of the provider;

N.8.5.4. Suspend referrals, registration, or authorizations; and

N.8.5.5. Report to the Department if issues are of a serious nature or remain unresolved.

N.9. Quality Improvement Initiatives

N.9.1. The Contractor shall identify, prioritize and submit for the Department's review and approval, as part of its Annual Quality Management Project Plan, quality

initiatives based on:

N.9.1.1. Data and experience available through the Department and the Contractor's experience in Connecticut and other states, if applicable;

N.9.1.2. The results of the member and provider satisfaction surveys;

N.9.1.3. The results of the clinical issues studies; and

N.9.1.4. Recommendations derived from the analysis of problems identified by the UM, ICM, Network Management, Provider Relations, Member Services Units, and through the complaints process.

N.9.2. The Contractor shall emphasize reduction of ethnic and racial health disparities in all quality improvement initiatives.

N.9.3. The Contractor shall implement quality improvement initiatives starting in year one of the contract in coordination with and with the approval of the Department. Initial quality improvement initiatives will be in the areas of:

N.9.3.1. Chronic pain management;

N.9.3.2. Breast, cervical, and colon cancer screening;

N.9.3.3. Tobacco cessation;

N.9.3.4. Depression screening;

N.9.3.5. EPSDT well visits;

N.9.3.6. Adult well visits;

N.9.3.7. Comprehensive diabetes care;

N.9.3.8. Asthma care;

N.9.3.9. Prenatal and postnatal care.

N.10. Provider Profiling

N.10.1. The Contractor shall, by February 1, 2012, and annually thereafter, produce for the Department a provider profiling strategy and methodology for review and approval.

N.10.2. The Contractor shall work collaboratively with the provider and consumer stakeholders to inform the provider profiling methodology.

N.10.3. The Contractor shall, at a minimum, develop provider profiles in two areas each contract year to be determined annually.

N.10.4. The Contractor's Network Managers (see N.13) shall share profiling results with providers, advise in the provider's development of continuous quality improvement plans and support providers and communities in the execution of the plans.

N.10.5. The profiling system shall enable the Department to profile provider performance and shall also support provider self-profiling.

N.11. Person Centered Medical Home/Health Home Performance Measurement

N.11.1. The Contractor shall, by January 11, 2012, and annually thereafter, produce for the Department a PCMH/HH performance measurement strategy and methodology for review and approval.

N.11.1.1. The performance measurement strategy shall encompass the range of PCMH/HH performance measures established by the Department in consultation with the Medicaid Care Management Oversight Council.

N.11.2. The Contractor shall work collaboratively with the PCMH/HH providers and consumer stakeholders to inform the performance measurement methodology.

N.11.3. The Contractor's Network Managers shall share profiling results with providers to support providers and communities continuous quality improvement activities.

N.11.4. The profiling system shall enable the Department to profile PCMH/HH performance and shall also support PCMH/HH self-profile.

N.12. Statewide Performance Measurement

N.12.1. The Contractor shall, by January 1, 2012, and annually thereafter, produce for the Department a statewide profiling strategy and methodology for review and approval.

N.12.1.1. The profiling strategy shall encompass the range of performance measures contained in Exhibit E: Reporting Matrix as amended by the Department in consultation with the Medicaid Care Management Oversight Council.

N.12.2. The Contractor will be required to carry out the full complement of audited HEDIS Medicaid measures including hybrid measures in accordance with NCQA standards.

N.12.3. The Contractor shall use claims data provided by the Department and shall contract with an NCQA accredited auditor.

N.12.4. The Contractor shall contract for or use the Contractor's quality management staff to undertake all field based chart reviews and other document

reviews as necessary to meet the HEDIS requirements.

N.13. Network Managers

N.13.1. The Contractor shall employ sufficient Network Managers to conduct the provider and PCMH/HH profiling activities outlined in N.11 and N.12.

N.13.2. The Contractor shall provide the Network Managers with training and ongoing supervision to support their role in analyzing network information, developing quality improvement plans, monitoring of critical incidents, and promoting the development of best practices within provider organizations.

N.13.3. The Contractor shall ensure that applicants for the Network Manager positions have:

N.13.3.1. Significant experience in the field of health and care management;

N.13.3.2. Demonstrated leadership and accomplishments in the management of health services;

N.13.3.3. Expertise in basic data analysis and reporting;

N.13.3.4. Demonstrated experience in helping to develop a continua of health systems;

N.13.3.5. Demonstrated experience in quality management;

N.13.3.6. The ability to develop and implement performance improvement plans; and

N.13.3.7. Experience in organizing and coordinating meetings while promoting communication and collaboration among stakeholders.

N.14. Annual Quality Management Project Plan Evaluation

N.14.1. The Contractor shall submit to the Department according to the schedule provided in the Reporting Matrix at Exhibit E, a comprehensive QM Program Evaluation Report utilizing the performance measures detailed in the Contractor's QM Plan. The evaluation components shall correspond to the components and to the schedule outlined in the approved Annual Quality Management Program Plan.

N.14.2. At a minimum the evaluation report shall include the following:

N.14.2.1. A description of completed and ongoing Provider and Member Surveys, Clinical Issue Studies, Ongoing QM Activities and annual QM Initiatives;

N.14.2.2. Summary of improvements in access, quality of care, coordination of physical and behavioral healthcare, and performance in other areas as a result of Ongoing QM Activities and QM Initiatives and evaluation of the overall

effectiveness of the Annual Quality Management Program Plan;

N.14.2.3. Summary of other trends in access, utilization, and quality of care (including but not limited to measures contained in the Reporting Matrix - Exhibit E) that provide an overall illustration of the health system's performance;

N.14.2.4. Assessment of utilization and other indicators that suggest patterns of potential inappropriate utilization and other types of utilization problems;

N.14.2.5. Assessment of provider network adequacy including instances of delayed service and transfers to higher or lower levels of care due to network inadequacy, adequacy of linguistic capacity, and cultural capacity of specialized outpatient services,

N.14.2.6. Assessment of provider network access based on standards defined by the Department. Access standards apply to life threatening and non-life threatening emergency care services, urgent care services and routine care services;

N.14.2.7. Evaluation of the Contractor's performance with respect to targets and standards described in the Reporting Matrix (Exhibit E), with proposed interventions to improve performance (corrective action plans) and proposed intervention measures;

N.14.2.8. Proposed QM initiatives and corrective actions including proactive action to improve member clinical functioning, sustain recovery, minimize crises and avert adverse outcomes and to remediate utilization problems; and Overall impression of the ASO's system operations and functioning with recommendations for remediation.

N.15. Critical Incidents

N.15.1. The Contractor shall report to the Department any critical incident or significant event within one (1) hour of becoming aware of the incident.

N.15.2. The Contractor shall report to the Department, on a quarterly and annual basis, critical incidents and significant events in the aggregate. Reports shall be submitted in accordance with timeframes outlined in the Reporting Matrix (Exhibit E).

N.16. The Bidder Shall

N.16.1. Propose a QM Program Plan outline based on the bidder's previous experience and modified to be responsive to this application.

N.16.2. Propose quality indicators and methods that might serve as effective measures of successful implementation during the first nine (9) months of

implementation.

N.16.3. Propose a methodology for meeting the requirements of the Annual QM Program Plan.

N.16.4. Propose a survey methodology for obtaining member and provider satisfaction and feedback regarding access, quality and the care experience.

N.16.5. Provide a flow chart and describe how the bidder will track, monitor, respond and resolve all complaints. The bidder shall identify if this process is manual or automated and describe each process in detail. This could include segregating those complaints that can be resolved by the Contractor versus those that would require the Department's assistance.

N.16.6. Propose a methodology to identify Clinical Study issues.

N.16.7. Propose a methodology to identify members with multiple emergency department admissions, and identify and refer for ICM high-risk members with multiple chronic conditions/co-occurring medical/behavioral health needs.

N.16.8. Propose position description and qualifications for network managers.

N.16.9. Propose a methodology and plan to identify and address provider relations issues (i.e., authorization problems, enrollment problems, data exchange problems and other issues).

N.16.10. Propose a methodology, including specific material, reports, data and events to initiate desk or on-site provider quality audits in response to quality of care complaints or incidents in order to improve the quality of care at specific provider sites.

N.16.11. Propose a methodology that clearly describes the process for establishing corrective action plans, and if necessary, provider sanctions based on the quality audit and subsequent findings.

N.16.12. Describe the proposed approach to conducting the required provider profiling activities as stated above.

N.16.13. Describe the proposed approach to conducting the required PCMH/HH performance measurement activities as stated above.

N.16.14. Describe the proposed approach to conducting the required statewide performance measurement.

N.16.14.1. Include specific information regarding all how the Contractor will administer this requirement using claims data provided by the Department and detail the plan for the gathering of information necessary to satisfy all hybrid measure requirements.

N.16.15. Describe how the provider profiling and PCMH/HH performance measurement system can be accessed by the Department for use in profiling individual providers and PCMH/HH providers.

N.16.16. Describe how the provider profiling and PCMH/HH performance measurement system can be accessed by providers to support their ongoing performance monitoring and quality improvement.

N.16.17. Describe whether and how this system might facilitate comparison with other similar providers or levels of care statewide.

O. PROVIDER RELATIONS

O.1. Introduction

O.1.1. The success of the ASO depends upon adequate client access to providers practicing the highest standards of clinical care The Contractor therefore must emphasize retention and recruitment of high quality providers.

O.1.2. Throughout the term of the contract the Contractor shall develop and maintain positive Contractor-Provider Relations; communicate with all providers in a professional and respectful manner; promote positive provider practices through communication and mutual education and provide administrative services in the most efficient manner possible in an effort to pose minimal burden on providers.

O.2. General Aims:

O.2.1. The Contractor shall promote on-going and seamless communication between providers and the Contractor. To accomplish this task the Contractor shall:

O.2.1.1. Include providers in the Contractor's committee structure, to give providers a direct voice in developing and monitoring clinical policies;

O.2.1.2. Offer providers' on-site consultation with respect to both clinical and administrative issues;

O.2.1.3. Work with providers to reduce administrative responsibilities through the use of the Contractor's bypass program, automated voice response (AVR) system, Web-enabled registration systems, and other technologies;

O.2.1.4. Provide encryption software upon request from a provider to provide for the exchange of member data via e-mail;

O.2.1.5. Post all policies and procedures, handbooks and other material, produced as a requirement under the contract resulting from this RFP and as determined by the Department, on the ASO Website. Provider websites must be readily and clearly accessible in a manner that allows providers quick access to important information;

O.2.1.6. Make all policies and procedures, handbooks and other material produced as a requirement under the contract resulting from this RFP and as determined by the Department, available to providers in electronic and written hard copy, if requested;

O.2.1.6.1. To the greatest extent possible, notify providers of impending policy or procedural changes at least 45 days prior to implementation;

O.2.1.7. Monitor Provider complaints and if, in the opinion of the Contractor, the complaints are of sufficient severity or frequency to warrant consideration for disenrollment from the Medicaid Fee-for-Service network, notify the Department of the Contractor's opinion.

O.2.1.8. Conduct provider satisfaction surveys at least once per year, sharing findings with provider advisors and involve the provider advisors in implementing corrective action as indicated;

O.2.1.9. Beginning January 1, 2012, provide the Department with a publication-ready newsletter for review and approval twice a year.

O.2.1.9.1. The Contractor shall ensure that the newsletter includes articles covering health topics of interest for providers who work both with children and adults, that appropriate medical professionals are involved in writing the assigned articles, and that the newsletters are posted to the ASO website once approved by the Department; and

O.2.1.10. Assist the Department with monitoring and training the provider community by offering individualized training to providers, targeting high volume providers or those providers with specific needs identified through monitoring reports, and tracking and monitoring all complaints as part of re-credentialing, and inform the Department if intervention is required in an urgent situation.

O.3. Provider Handbook

O.3.1. The Contractor shall, by January 1, 2012, produce a Provider Handbook for the Department's review and approval prior to its distribution, and shall make this handbook available on the website.

O.3.2. The Contractor shall make the printed form of this handbook available for distribution upon request.

O.3.3. The Provider Handbook shall include but may not be limited to the following:

O.3.3.1. Contractor corporate information;

O.3.3.2. Confidentiality provisions;

O.3.3.3. Mission statements of the Department and the ASO;

O.3.3.4. Descriptive process for accessing services under the ASO;

O.3.3.5. Procedures for communicating with the Department and the ASO;

O.3.3.6. Summary of service and benefit structure;

O.3.3.7. Description of formularies or preferred drug lists for enrolled members;

O.3.3.8. Procedures for submitting complaints and appeals;

O.3.3.9. Procedures for service authorization and registration;

O.3.3.10. Procedures for using web-based provider services;

O.3.3.11. Summary of UM requirements;

O.3.3.12. Summary of claims procedures and the Department's MMIS Contractor contact information;

O.3.3.13. Names and contact information of Provider Relations staff; and

O.3.3.14. Information on how clients may access pharmacy, transportation, behavioral and dental services.

O.4. Provider Notification

O.4.1. Throughout the term of the contract resulting from this RFP the Contractor shall be required to alert providers to modifications in the Provider Handbook and to changes in provider requirements that are not otherwise communicated by the Department or its MMIS Contractor. To accomplish this task the Contractor shall:

O.4.1.1. Request and obtain from providers an e-mail address, so they can be alerted to access the Contractor's ASO Website to download updates to the provider handbook, provider bulletins, and provider requirements;

O.4.1.2. E-mail to providers and publish on the Contractor's ASO Website any clarification or direction on matters not otherwise communicated by the Department; and

O.4.1.3. Post notification of policy changes on the Contractor's ASO Website.

O.5. Provider Orientation

O.5.1. During the first year of the contract resulting from this RFP, the Contractor shall conduct an initial statewide provider orientation initiative and at least two subsequent rounds of provider orientation sessions in five different geographic areas of the State. The schedule and specific locations for the orientation sessions

shall be submitted to and approved in advance by the Department.

O.5.2. The Contractor shall work with representatives of the provider community to develop the agenda for the initial statewide provider orientation to identify the most effective ways to encourage attendance.

O.5.3. The Contractor shall alert providers to the various meetings through direct mailings, coordination with professional organizations, notices posted to the ASO website and through personal invitations issued by Contractor staff.

O.5.4. The Contractor shall, following the initial statewide and local provider orientation sessions, determine in conjunction with the Department, whether the initial orientation sessions should be repeated at one or more locations to further encourage provider participation.

O.6. Provider Training and Targeted Technical Assistance

O.6.1. Throughout the term of the contract the Contractor shall:

O.6.1.1. Offer training and technical assistance to providers on clinical topics, including introducing evidence-based and emerging best practices, as approved by the Department,

O.6.1.2. Offer training and technical assistance to providers on a person-centered approach to care, as approved by the Department;

O.6.1.3. Develop and implement an ongoing program of provider workshops and training sessions designed to meet the specialized needs and interests of providers; and

O.6.1.4. Have available both clinical and administrative staff to provide targeted technical assistance onsite at the request of network providers and also non-network providers seeking to become network providers.

O.7. Provider Inquiries and Complaints

O.8. Throughout the term of the Contract the Contractor shall:

O.8.1. Using a reporting grid to be developed by the Department, track and manage all provider inquiries and complaints related to clinical and administrative services covered under the contract resulting from this RFP, and direct all complaints related to behavioral health, pharmacy, dental and transportation services to the responsible Department vendor.

O.8.2. Ensure that all provider inquiries and complaints are addressed and resolved in compliance with the Contractor’s approved QM Plan, and no later than 30 days from receipt.

O.8.3. Ensure that all Provider inquiries and complaints are addressed and resolved in

compliance with the Contractor's approved QM Plan and no later than 30 days from receipt.

O.8.4. Provide the Department with a regular report outlining the Contractor's compliance with required timeframes and notifications related to inquiries and complaints. The Department and the Contractor shall agree to the form, content and frequency of the report in advance.

O.8.5. Utilize the Contractor's management information system(s) (MIS) to track complaint related information and provide this data to the Department upon request. Such data shall include, but may not be limited to the following:

O.8.5.1. Caller Name;

O.8.5.2. Date and Time of complaint;

O.8.5.3. The nature of the complaint;

O.8.5.4. Category/type of complaint including information regarding location and specific professional service type if complaints relate to access;

O.8.5.5. Actions taken to address complaint;

O.8.5.6. Complaint resolution outcome, date and time; and

O.8.5.7. Narrative details regarding complaint.

O.9. Web-based Communication Solution

O.9.1. By 1/1/2012 the Contractor shall develop and implement a Website specifically to serve ASO providers and members and register the address www.ct.gov/dss/XX (hereinafter referred to as the "ASO Website").

O.9.2. The Contractor shall ensure that the ASO Website provides information about the Contractor's services, a link to the Department's primary websites and ASO related websites (e.g., www.ctdssmap.com) and a link to the Contractor's corporate website. Coordination of this for the Department's website should be done through the Department's Webmaster.

O.9.3. The Contractor shall, in collaboration with the Department, determine what program content is to be published on the ASO Website,

O.9.4. The Contractor shall provide Web-enabled transactional capabilities through the ASO Website. Such capabilities shall include but may not be limited to:

O.9.4.1. Provider/member inquiries;

O.9.4.2. Submission of initial request for authorization, registration and re-registration;

O.9.4.3. Authorization/registration provider look-up capability including authorization/registration number, authorization status indicator for pending authorizations, begin and end dates, number of units authorized, units available (or used), and payable codes under authorization;

O.9.4.4. Electronic Transport System (ETS), a communication system designed for the interchange of electronic data files between providers and the Department;

O.9.4.5. Contractor's Online Provider Services application to allow providers to register care and verify eligibility online and to submit requests for continued care beyond the initially authorized/registered services;

O.9.4.6. A Web-based referral search system that will allow Contractor's and Department's staff, providers, members and any other interested persons to locate network providers through an online searchable database.

O.9.4.6.1. The searchable database shall include network providers and facilities with information regarding areas of clinical specialization, race/ethnicity, languages spoken, disciplines, and program types.

O.9.4.6.2. The system shall permit searches using any combination of the following criteria: provider category (e.g., hospital, clinic, physician and others as determined by the Department); service type (e.g., physician, laboratory, clinic, home health care, durable medical equipment, optometrist); zip code; population served; languages spoken; sex of provider; ethnicity of provider; clinical specialty; last name; and first name.

O.9.4.6.3. Persons accessing the referral search system shall be able to sort provider search results by driving distance, list the details available on each provider (e.g., specialties and languages), and include a map showing locations of provider offices in relation to a specified location; and

O.9.4.6.4. Providers shall have the ability to securely initiate updates of the provider's information in the searchable database.

O.9.4.7. The Contractor shall ensure that the Website includes an internet "library" of health information for providers, ASO members, families and the Department's staff. The library shall provide comprehensive information and practical recommendations related to health conditions, wellness, and services in both English and Spanish.

O.10. The Bidder Shall

O.10.1. Propose its method for providing on-going and seamless communication between providers and the Contractor.

O.10.2. Propose a provider notification process.

O.10.3. Propose a plan for an orientation program and targeted technical assistance for providers with specific attention to engaging providers.

O.10.4. Propose a methodology to identify providers who require targeted training.

O.10.5. Propose a plan to assist with the facilitation of biannual regional community meetings for the purposes of information sharing and feedback with providers, consumers and advocacy groups.

O.10.6. Propose a mechanism to track and manage all provider inquiries, complaints and/or grievances.

O.10.7. Propose a web-based solution to address communication needs of providers including the way the bidder's Connecticut website will relate to the bidder's entire web address and the ASO website.

P. PROVIDER AND MEDICAL HOME/HEALTH HOME NETWORK DEVELOPMENT

P.1. Introduction

P.1.1. The success of the ASO depends upon adequate client access to providers practicing the highest standards of clinical care The Contractor therefore must emphasize retention and recruitment of high quality providers. Throughout the term of the Contract, the Contractor shall provide network management and development functions including the development of a provider file, qualifications review, assess demand, network adequacy analysis, and network development assistance.

P.1.2. The Department expects the Contractor to facilitate expansion of the CMAP provider network to support adequate client access to a complete range of provider types and specialties.

P.1.3. It is also expected that the Contractor will provide technical assistance in the field and data to support the emergence and ongoing operations of person-centered medical homes, health homes, and other service delivery innovations, such as Integrated Care Organizations. Medical homes will be established as early as January 1, 2012.

P.1.4. The Contractor shall interact with the providers as an administrative agent on behalf of the Department. In this capacity, the Contractor shall assist the Department in developing and maintaining the provider and PCMH/HH network sufficient to ensure the delivery of all covered services to all members.

P.1.5. The Contractor may not contract with providers in the Connecticut Medical Assistance Program Provider network for the provision of covered services to ASO members.

P.1.6. The Contractor shall obtain provider network data from the Department and shall

build and maintain a provider file as specified in the “Information Systems” Section.

P.2. Access to Provider Files

P.2.1. Throughout the term of the Contract the Contractor shall:

P.2.1.1. Ensure that Contractor’s staff have immediate access to all provider files through the integrated management information system to allow staff to search for a provider appropriate to a member’s needs, preferences, and location; and

P.2.1.2. Ensure that Contractor’s clinical staff and Member/Provider Services staff, both in the Service Center and in the field, have wireless, real-time access to the provider file via their computers.

P.3. Provider Search Function

P.3.1. The Contractor shall ensure that the Provider Search Function in the Contractor’s MIS allows the Contractor staff to conduct provider searches utilizing any combination of the following criteria:

P.3.1.1. Provider type;

P.3.1.2. Service type/level of care;

P.3.1.3. Zip Code;

P.3.1.4. Population Served;

P.3.1.5. Language;

P.3.1.6. Gender;

P.3.1.7. Race/Ethnicity of Provider (when available);

P.3.1.8. Specialty, using the CMAP provider specialties

P.3.1.9. Provider Last Name;

P.3.1.10. Provider First Name;

P.3.1.11. Provider Medicaid Number; Provider Number; and

P.3.1.12. Whether the provider is accepting new patients.

P.4. Network Assessment

P.4.1. The Contractor shall assess the size and scope of the current CMAP contracted provider network to assist the Department in determining the need for provider

recruitment.

P.4.2. The Contractor shall:

P.4.2.1. Send data verification forms, within 30 days of implementation, to all CMAP providers, requesting among other things, identification of their clinical specialties;

P.4.2.2. Establish and update provider file information with respect to whether providers are accepting referrals;

P.4.2.3. Load the provider and utilization data into the Contractor's MIS, perform a gap analysis and generate a density report to determine network inadequacies; If the gap analysis performed during implementation indicates a need for additional providers, the Contractor shall outreach to those providers to facilitate enrollment;

P.4.3. The Contractor shall outreach to the Department's record of HUSKY MCO network providers who have not enrolled as of October 1, 2011; and

P.4.3.1. Perform a gap analysis regularly (GeoAccess study) and density report at least quarterly including only those providers who are accepting new patients. Focus on priority areas as determined by the Department and Contractor's advisory committees.

P.4.3.2. Priority areas include language capacity, specialty services and appointment times;

P.4.3.3. Implement ongoing provider monitoring processes to assure network PCPs adhere to timely scheduling of appointments through the Department defined methodology for random appointment call/audit;

P.4.3.4. Work with PCP practices to offer expanded hours (i.e. evenings, weekends); Evaluate the utilization and effectiveness of 24/7 nurseline services or 24 hour physician lines.

P.4.4. Throughout the term of the Contract, the Contractor shall identify service gaps in a variety of other ways using a variety of data sources including:

P.4.4.1. Tracking and trending information on member complaints and services requested but not available;

P.4.4.2. Requesting the Contractor's advisory committees to identify services that are needed but unavailable;

P.4.4.3. Monitoring services for which authorization is continued for administrative reasons (e.g., lack of essential aftercare services); Monitoring penetration rates by age, location and ethnic/minority;

P.4.4.4. Monitoring consumer-reported satisfaction with access to services;

P.4.4.5. Monitoring population growth; and

P.4.4.6. Utilizing findings of other local research.

P.5. Network Development

P.5.1. The Contractor shall assist the Department in addressing deficiencies in the Connecticut Medical Assistance Program Provider Network by developing the provider network in geographic areas that do not provide adequate access to sufficient providers in a range of types and specialties to support adequate access to covered services. Specifically, the Contractor shall

P.5.1.1. Encourage the use of provider outreach activities, such as scheduled office visits, recruiting and information stations at professional meetings, sponsoring of evidence-based continuing education activities;

P.5.1.2. Offer clinical training at no additional charge to the Department or to the providers;

P.5.1.3. Work with trade organizations and licensing boards to actively recruit providers;

P.5.1.4. Work with existing CMAP providers to expand existing capacity and add new services; Identify potential providers and provide them with information and technical assistance regarding the provider enrollment process and provider service and performance standards to support participation as a network provider; and

P.5.1.5. Coordinate with the Department's MMIS Contractor and the Department as necessary to facilitate enrollment of new providers, identify impediments to enrollment, and develop new services for existing network providers.

P.6. Critical Access and Single Case Agreements

P.6.1. The Contractor shall negotiate and facilitate the execution of special service agreements between a provider and the Department on a case-by-case basis to address critical access issues.

P.6.2. The terms of such agreements may be negotiated without the participation of the Department but the final terms of the agreement shall be subject to approval by the Department.

P.6.3. Such agreements shall be entered into to address access issues including, but not limited to:

P.6.3.1. Provision of a service that is covered, but unavailable in network or in the client's geographic area, or provided out of state when the service is not

performed by a Connecticut provider;

P.6.3.2. Provision of a service to eligible members who are temporarily out-of-state and in need of services; and

P.6.3.3. Provision of a service that is not in the network, but is covered under Medicaid EPSDT.

P.6.4. The Contractor shall coordinate with the Department and its MMIS contractor to enroll providers with whom a special service agreement has been negotiated that will be payable through the MMIS.

P.7. Payment Related Troubleshooting and Technical Assistance

P.7.1. The Contractor shall facilitate the identification and resolution of provider payment problems. The Contractor shall:

P.7.1.1. Attend regular meetings hosted by the Department and attended by the Department's fiscal agent to address operational issues that are or may impact providers.

P.7.1.2. Use overall and provider specific payment monitoring reports in coordination with the Department's MMIS Contractor to identify payment problems and diagnose the nature of those problems (i.e., authorization related vs. claims adjudication related).

P.7.1.3. Participate in a rapid response team consisting of the Department's MMIS Contractor personnel and Contractor personnel to resolve issues related to timely and accurate claims payment.

P.7.2. The Contractor shall, by 12/1/2011, present to the Department for its review and approval, a plan for coordinating problem assessment and intervention.

P.7.3. The plan shall include provisions for on-site assistance by a rapid response team when problems persist for more than 60 days.

P.8. The Bidder Shall

P.8.1. Propose a plan for building and maintaining a provider file with recommended minimum data elements, and demonstrate the utility of the system and ease of access to provider file data by the Utilization Management, Intensive Care Management, and Recipient Services units.

P.8.2. Demonstrate how the provider database identifies where the services reside by location, provider type, and specialty.

P.8.3. Propose a plan for the recruitment and retention of providers to address network deficiencies, with emphasis on adequate access to primary care providers and to a complete range of specialist types.

P.8.4. Propose a plan to support expanded client access to care, including but not limited to identification of providers that are accepting new patients, offering expanded hours (i.e. evenings, weekends), and offer other services of importance to special populations (cultural competence, special expertise in caring for specific clinical conditions).

P.8.5. Propose approaches, in addition to those described in F.7.1.2., to identify and resolve provider authorization and payment related problems.

P.8.6. Propose a reporting format to support monitoring of network development, including standardize reports access reports with only providers that are accepting new patients.

P.8.7. Propose a plan for providing technical assistance and support to providers interested in becoming medical homes or health homes.

P.8.8. Propose operational procedures for the payment of providers under special service agreements, through the Department's MMIS.

Q. MEMBER SERVICES

Q.1. General Requirements

Q.1.1. Throughout the term of the Contract the Contractor's member services staff shall provide non-clinical information to members and when appropriate provide immediate access to clinical staff for care related assistance.

Q.1.2. The Contractor shall ensure that member information is clearly communicated in a manner that is culturally sensitive and should supply sufficient information that enables members to make informed decisions to access health services.

Q.1.3. Throughout the term of the contract the Contractor shall ensure that all member services staff shall demonstrate professionalism, respect, and communicate in a culturally appropriate manner with members.

Q.1.4. The Contractor shall staff member services with competent, diverse professionals including Spanish-speaking individuals in order to best serve the needs of members.

Q.1.5. The Contractor shall ensure that TDD/TTY and language translation services are available for those individuals who require them.

Q.1.6. The Contractor shall identify a "Key Person" responsible for the performance of the Member Services unit.

Q.1.7. The Contractor shall develop and implement a formal training program and curriculum for staff that respond to member inquiries.

Q.1.7.1. The training program shall include training in how to recognize members

that may need ICM and to make referrals as appropriate.

Q.1.8. The Contractor shall develop a reference manual for member service representatives to use during daily operations.

Q.1.9. The Contractor staff shall provide members with information that facilitates access to covered services and allows successful navigation of the health service system;

Q.1.10. The Contractor shall develop, plan and assist members with information related to community based, free care initiatives and support groups.

Q.1.11. The Contractor staff shall respond to member clinical care decision inquiries in a manner that promotes member self-direction and involvement; and

Q.1.12. The Contractor staff shall initiate a warm transfer for callers who require behavioral or dental services to the appropriate ASO, or instruct individuals who are not enrolled how they can apply for medical assistance (regional office, 211).

Q.1.13. The Contractor shall develop a data base of providers as further described in the Provider Network section identifying providers with cultural competency and linguistic capabilities; and shall use this information to refer individuals to health services that are culturally and linguistically responsive to the preferences of individuals.

Q.1.14. When requested by individuals, the Contractor shall identify participating providers, facilitate access, and assist with appointment scheduling when necessary. The Contractor shall develop a database to support this function as necessary.

Q.2. Policies and Procedures

Q.2.1. The Contractor shall, no later than December 1, 2011, develop and submit to the Department for their review and approval a Member Inquiry Process to include policies and procedures for resolving and responding to member inquiries. The policies and procedures shall address the tracking and reporting of the following:

Q.2.1.1. Complaints regarding the Contractor's performance;

Q.2.1.2. Complaints related to the service delivery system;

Q.2.1.3. Complaints related to specific providers;

Q.2.1.4. Resolution of complaints not later than 30 days from receipt;

Q.2.1.5. Routine, urgent and emergent (crisis) calls;

Q.2.1.6. Inquiries regarding the status of any denial, reduction, suspension or termination of services;

Q.2.1.7. Inquiries related to the status of authorization requests;

Q.2.1.8. Inquiries regarding member rights and responsibilities including those related to complaints and appeals;

Q.2.1.9. Forms and instructions for filing a written complaint;

Q.2.1.10. Requests for referral, taking into consideration linguistic and cultural preferences when requested;

Q.2.1.11. Request to facilitate access and assist with appointment scheduling when necessary; Requests for coverage information including benefits and eligibility;

Q.2.1.12. Inquiries related to community based free care initiatives and support groups; and

Q.2.1.13. Inquiries regarding information related to the Behavioral Health or Dental Partnerships.

Q.3. Transportation

Q.3.1. Throughout the term of the contract the Contractor, through its member services staff shall facilitate and coordinate access to transportation services. The Contractor shall:

Q.3.1.1. Facilitate and coordinate access to transportation services for any Medicaid eligible individual by referring the individual to the appropriate Department transportation services broker.

Q.3.1.2. Offer to provide a warm transfer to the transportation broker; and

Q.3.1.3. Ask the caller to call the Contractor back if problems are encountered in accessing transportation.

Q.4. Semi-Annual Community Meetings

Q.4.1. The Contractor's staff shall coordinate with staff from the Department in the conduct of semi-annual community meetings. The purpose of the community meetings shall be to share information and feedback with members, family members, advocacy groups and providers.

Q.4.2. The community meetings shall be conducted in at least five (5) locations throughout the State, as proposed by the Contractor and approved by the Department.

Q.4.3. The first series of community meetings shall be conducted between November 1, 2011 and December 31, 2011 and shall focus on orienting members of the community to the new ASO initiative.

Q.4.4. The Contractor shall:

Q.4.4.1. Develop agendas with common topics across all regions as well as specific local topics suggested by local stakeholders;

Q.4.4.2. Select sites and times that will encourage the largest number of participants;

Q.4.4.3. Publicize the event throughout the region and across the State;

Q.4.4.4. Arrange for a keynote speaker, panel presentation or main focus; and

Q.4.4.5. Provide a mechanism for all attendees to evaluate the meeting and offer suggestions for future regional committee meetings.

Q.5. Member Brochure

Q.5.1. The Contractor shall develop an informational member brochure by November 1, 2011 to be written at no greater than a fourth grade reading level, in both English and Spanish. The contents of the brochure shall:

Q.5.1.1. Explain benefits for members;

Q.5.1.2. Describe how to access providers;

Q.5.1.3. Describe how to contact the Contractor for assistance; and Describe member rights and responsibilities, including grievances, complaints and appeals.

Q.5.2. The Contractor shall produce, print, and distribute the informational member brochure according to a plan approved by the Department and mail a brochure to any member or provider upon request.

Q.5.3. The Contractor shall supply the Department with brochures to be distributed by the Department at the time that eligibility is granted and supply large provider sites with brochures for provider distribution at their sites of service.

Q.5.4. The Contractor shall revise and update the brochure as required by the Department but not more often than annually and distribute the revised brochures according to the distribution plan approved by the Department. The Contractor will consider other means of communication including web-based video feeds.

Q.6. Member Handbook

Q.6.1. The Contractor shall, by April 1, 2012, develop a Member Handbook. The Member Handbook shall include:

Q.6.1.1. The benefits available to members;

Q.6.1.2. The procedures for accessing services covered under the ASO and

related services such as transportation and pharmacy for which services may be accessed through the ASO; and

Q.6.1.3. Rights and responsibilities, including Notices of Action, appeal and complaints rights.

Q.6.2. The Contractor shall post the Member Handbook on the ASO Website and shall print and mail or otherwise arrange delivery of this handbook to members upon request.

Q.6.3. The Contractor's proposal for the ASO Website shall include a member services section and such section shall:

Q.6.3.1. contain information for members and their families concerning health information for members;

Q.6.3.2. ensure that the website has the capability of exchanging ASO information and member information with providers and members;

Q.6.3.3. Include the text of the Member Handbook; and

Q.6.3.4. Include security provisions approved in advance and required by the Department.

Q.7. The Bidder Shall

Q.7.1. Propose and fully describe the staffing needed to adequately address member services inquiries. The description shall include:

Q.7.1.1. A flow chart and narrative that describes and justifies the relationship between the member services staff and other on-call staff with clinical expertise and Quality Management staff;

Q.7.1.2. A staffing schedule to operate the system as described above;

Q.7.2. Provide a description of the decision process that member services staff will use to respond to requests for services and/or information. Recognizing that non-clinical staff will answer some member services phone calls that may require clinical judgment, the bidder shall fully explain its method to redirect calls to clinical staff;

Q.7.3. Provide an outline of a reference manual for member services staff;

Q.7.4. Provide a description of a member services training program the bidder implemented in other public sector health programs.

Q.7.5. Describe the Contractor's strategy for responding to member access inquiries and complaints, including a description of how complaint related information is captured to support complaint reporting as established in Exhibit E: Reporting Matrix. Include a description of the process for identifying participating providers,

facilitating access, and assisting with appointment scheduling when necessary.

Q.7.6. Describe the bidder's website capabilities available for use in its public sector managed care programs, including web based video capabilities.

R. TELEPHONE CALL MANAGEMENT

R.1. General Requirements

R.1.1. Throughout the term of the Contract, the Contractor shall provide Telephone Call Management Services in a manner that facilitates member and provider access to information and services in an efficient, convenient, and user-friendly manner. This shall include the use of both automatic voice response system (AVR) and staffed lines, the use of industry standard technology to monitor and distribute call volume and the ability to provide detailed and timely reporting for both day-to-day operational management and ongoing service quality monitoring.

R.1.2. The Contractor shall provide and operate call management services through a location in Connecticut. After hours services, such as crisis triage, with the Department's advance approval, be managed out of state but within the United States.

R.1.3. The Contractor shall include up to (3) nationwide toll free lines, one of which shall be dedicated to fax communications.

R.1.4. The Contractor shall develop, implement and maintain operational procedures, manuals, forms, and reports necessary for the smooth operation of the Telephone Call Management Services.

R.2. Line Specifications

R.2.1. The Contractor shall establish and maintain a toll free telephone line for members and providers with the following specifications:

R.2.1.1. Access to a limited menu automated voice response (AVR) system. Speech recognition is optional;

R.2.1.2. Ability to receive transferred calls from other AVR Systems;

R.2.1.3. Ability to transfer calls to local departmental offices, as specified by the Department;

R.2.1.4. Ability to warm transfer to the Department and DEPARTMENT's agents for eligibility/ enrollment, dental, behavioral health, pharmacy, transportation, and claims services;

R.2.1.5. Ability to immediately transfer calls to a direct contact with a service representative on a priority basis without the caller having to listen to AVR menu options;

R.2.1.6. Conferencing capability;

R.2.1.7. TDD/TTY capability for hearing-impaired;

R.2.1.8. Multi-lingual Capabilities;

R.2.1.9. Overflow capability; and

R.2.1.10. Voicemail capability.

R.2.2. The Contractor shall establish and maintain the following menu options for members that call the main toll free telephone line:

R.2.2.1. Crisis Calls. The crisis calls that are received during normal business hours shall be routed to clinical staff. Crisis calls that occur after business hours shall be handled in a manner agreeable to the Department and the Contractor; and

R.2.2.2. Member Services. The Member Services Line shall enable members to call with questions, information and clinical requests during normal business hours.

R.2.3. The Contractor shall establish and maintain the following menu options for providers that call the main toll free telephone line:

R.2.3.1. Authorization requests twenty-four (24) hours a day and seven (7) days per week;

R.2.3.2. Provider Services during normal business hours; and

R.2.3.3. Authorization Verification: This option shall allow a provider to obtain information regarding the status of an authorization request.

R.3. Performance Specifications

R.3.1. Throughout the term of the Contract the Contractor shall meet or exceed the following Performance Specifications for Telephone Call Management. The Contractor shall:

R.3.1.1. Ensure that the AVR system provides the options menu to all callers within two (2) rings;

R.3.1.2. Ensure that the member and provider call-in lines never have a busy signal;

R.3.1.3. During normal business hours, provide sufficient and appropriate staff to answer all AVR transferred crisis calls and answer 100% of such calls within fifteen (15) seconds with a live person, and maintain an abandonment rate of less than 5%.

R.3.1.3.1. When crisis calls are not answered within the first fifteen (15) seconds, the AVR shall initiate a recorded message encouraging a caller to remain on the line and assuring a caller that a qualified staff person will answer the call momentarily;

R.3.1.4. After business hours, provide sufficient and appropriate staff to answer all AVR transferred crisis calls and dispatch the caller to a live person with the appropriate mobile crisis team or program the phone system to automatically distribute the caller to the appropriate crisis line, as described above.

R.3.1.5. All crisis calls shall be answered within fifteen (15) seconds or automated phone transfers shall occur within ten (10) seconds;

R.3.1.6. Provide sufficient and appropriate staff to answer all AVR transferred calls from the member services menu and shall answer 90% of calls with a live person within thirty (30) seconds and maintain an abandonment rate under 5% during Normal Business Hours.

R.3.1.7. During non-business hours when a staff person is not available for routine calls, the AVR shall respond with a recording within ten (10) seconds of the AVR call activation, instructing the caller to call back during normal business hours;

R.3.1.8. Produce a monthly report for the Department's review that documents each rerouting incident (including AVR transferred crisis calls) the answer time and the associated reason for the rerouting. This report shall be identified as the Network Call Rerouting (NCR) Report;

R.3.1.9. Provide sufficient and appropriate staff to answer all AVR transferred calls to the Authorization Line 24 hours a day, seven (7) days a week for providers, who shall answer 90% of such calls with a live person within (thirty) 30 seconds and maintain an abandonment rate of less than 5%.

R.3.1.9.1. When a staff person is not available, a recording shall respond every thirty (30) seconds instructing the caller to wait for the next available agent;

R.3.2. Provide sufficient and appropriate staff to answer all AVR transferred calls to "Provider Services" who shall answer 90% of calls with a live person within thirty (30) seconds and maintain an abandonment rate under 5% during Normal Business Hours.

R.3.2.1. During non-business hours when a staff person is not available, the AVR shall respond with a recording within ten (10) seconds of the AVR call activation instructing the caller to call back during normal business hours;

R.3.3. Ensure that Contractor's staff and AVR can communicate in English and Spanish on an as needed basis and that access is provided to a language line twenty-four

hours a day, seven days a week to serve members; and

R.3.4. Ensure that Contractor's telephone staff greets all callers, identify themselves by first name when answering and always treat the caller in a responsive and courteous manner.

R.4. Automatic Call Distribution Reporting

R.4.1. Throughout the term of the Contract the Contractor shall establish and maintain a functioning automatic call distribution (ACD) call reporting system that, at a minimum, has the capacity to record and aggregate the following information by AVR line:

R.4.1.1. Number of incoming calls;

R.4.1.2. Total number of answered calls by Contractor staff;

R.4.1.3. Average number of calls answered by each Contractor staff member;

R.4.1.4. Average call wait time by staff member;

R.4.1.5. Average talk time by staff member;

R.4.1.6. Percent of crisis calls answered by staff in less than fifteen (15) seconds during normal business hours after the selection of a menu option;

R.4.1.7. Percent of crisis calls answered by staff in less than fifteen (15) seconds or the systematic transfer within ten (10) seconds during after hours after the selection of a menu option;

R.4.1.8. Percent of routine Member Services calls answered by staff in less than thirty (30) seconds after the selection of a menu option;

R.4.1.9. Percent of provider Authorization calls answered by staff in less than thirty (30) seconds after the selection of a menu option;

R.4.1.10. Percent of Provider Services calls answered by staff in less than thirty (30) seconds after the selection of a menu option;

R.4.1.11. Number of calls placed on hold and length of time on hold; and

R.4.1.12. Number and percent of abandoned calls. (For purposes of this section abandonment refers to those calls abandoned 30 seconds after the entire menu selection has been played). The call abandonment rate shall be measured by each hour of the day and averaged for each month.

R.4.2. The Contractor shall maintain phone statistics daily and shall tally and submit the statistics to the Department in accordance with the reporting schedule and format outlined in Exhibit E, Reporting Matrix. The Department reserves the right to change the reporting timeframe for these reports; however, any revised timeframes

must be mutually agreed upon by the Department and the Contractor.

R.5. The Bidder Shall

R.5.1. Describe and justify the capabilities of the phone system to support the requirements of the contract including:

R.5.1.1. The number of phone lines;

R.5.1.2. Anticipated number of calls by time of day and day of the week by service line including peak call times;

R.5.1.3. Number and type of or job classification of staff including experienced staff assigned to the Crisis Line, Member Services Line and Provider Lines by time of day and day of the week;

R.5.1.4. A proposed methodology to monitor the performance specifications listed above in N.3;

R.5.2. Describe its Disaster Recovery Plan including:

R.5.2.1. Plan to respond to phone calls seamlessly in the event of local power failures, phone system failures, or other emergencies;

R.5.2.2. Plan to provide operator response to calls when the number of calls exceeds the anticipated call demand;

R.5.3. Describe its comprehensive inbound and outbound AVR system to be operated within the parameters described above;

R.5.4. Propose a plan to accommodate the cultural and language needs of individuals who call in to the AVR;

R.5.5. Describe its training requirements and standards related to Member Services; and

R.5.6. Describe its staffing ratios to handle the expected volume of calls coming into the Telephone Call Management Center as well as its contingency plan for when its staffing cannot fully support the call volume as identified by its staffing ratios.

S. DATA REPORTING REQUIREMENTS

S.1. General Requirements

S.1.1. The Contractor shall store all operational data collected in an information system that is compliant with Open Database Connectivity Standards (ODBC) and allow for easy data capture;

S.1.2. The Contractor shall ensure that the information system's reporting capacity is flexible and able to use data elements from different functions or processes as

required to meet the program reporting specifications described in the contract resulting from this RFP.

S.1.3. The Contractor shall provide the Department with a mutually agreeable electronic or Web-based file format of the MIS data dictionary of all data elements in all databases maintained in association with the contract resulting from this RFP.

S.1.4. The Contractor shall ensure that any database used in association with the contract resulting from this RFP can execute ANSI SQL.

S.1.5. The Contractor shall respond to questions or issues regarding data and/or reports presented to the Contractor within five (5) business days unless otherwise specified;

S.1.6. The Contractor shall provide access to detailed and summary information that the Contractor maintains regarding UM decisions, information on other registration services, UM staff coverage, appeals and complaints, and related data in conjunction with the authorization process.

S.2. Report Production, Integrity and Timeliness

S.2.1. The Contractor shall establish and notify the Department of the “Key Person” responsible for the coordination of the transmission of reports, correction of errors associated with the reports, as well as the resolution of any follow up questions.

S.2.2. The Contractor shall be required to submit to the Department certain reports regarding the Contractor's activities

S.2.3. The Contractor shall track report requests and work hours expended to satisfy the request.

S.2.4. The Contractor shall comply with requests from the Department to modify or add to the reporting requirements set forth herein unless the Contractor demonstrates to the Department that to meet such requirements, there must be a modification to the functional design of the information systems or increased staffing which will result in additional costs to the Contractor.

S.2.5. The Contractor shall provide the Department on or before October 1, 2011, for its review and approval the processes and controls implemented by the Contractor to ensure “data integrity”, defined as the ability to ensure data presented in reports are accurate (e.g. “reporting accuracy”).

S.2.6. Be required to submit to the Department certain reports regarding the Contractor's activities under this Contract Amendment.

S.2.7. The Contractor and the Department agree that the required reports, including due dates and prescribed format and medium are memorialized in Exhibit E - Reporting Matrix.

S.2.8. The Contractor shall be responsible for the production of all HEDIS designated reports listed in Exhibit E - Reporting Matrix including the use of HEDIS certified software and independent audit requirements.

S.2.9. Whenever the due date for any report falls on a day other than a Business Day, such due date shall be the first Business Day following such day.

S.2.10. The Contractor and the Department agree that the parties may desire to change Exhibit E - Reporting Matrix. Such changes may include the addition of new reports, the deletion of existing reports and/or changes to due dates, prescribed formats and medium.

S.2.11. The Contractor and the Department may agree to change Exhibit E, however, such change shall only be effective as of the date that the Department and the Contractor agree, in writing, to the change.

S.2.12. The Contractor shall not be held liable for the failure to comply with a reporting requirement set forth in Exhibit E, as changed by agreement of the parties from time to time, in the event that the Contractor's failure is a result of the Department's failure to provide the necessary data and/or data extracts.

S.2.13. The Contractor shall produce all reports accurately with minimal revisions following submission.

S.2.14. The Contractor shall advise the Department, within one (1) business day, when the Contractor identifies an error in a line item of a report and submit a corrected report within five (5) business days of becoming aware of the error.

S.2.15. The Contractor shall specify on the corrected report the element that changed, the cause of the error and the guidelines that the Contractor shall implement to prevent future occurrences.

S.2.16. If it is apparent that the submission date for a report will not be met, the Contractor shall request in writing an extension for submission. Such request must be received by the Department no later than one business day before the scheduled due date of the report.

S.3. Data Storage and Elements

S.3.1. In addition to the data elements necessary to complete the reports in Exhibit E and as described in the "Utilization Management" and "Quality Management" Sections, the Contractor shall store data with report programming flexibility to produce, sort and summarize reports that include one or more of the following data elements:

S.3.1.1. EMS Unique Client Identifier;

S.3.1.2. Age (including summarization by age bands and or focus on a specific

age, including those age bands specified in Exhibit E);

S.3.1.3. Gender;

S.3.1.4. Diagnoses;

S.3.1.5. Significant co-morbidities, including pregnancy;

S.3.1.6. ICM Indicators

S.3.1.7. BHP ICM co-management;

S.3.1.8. Local areas as defined by the Department;

S.3.1.9. Program (ABD, LIA, Family, CHIP, Charter Oak) and special population identifier if any;

S.3.1.10. PCP assignment

S.3.1.11. PCMH/HH attribution;

S.3.1.12. ICO attribution;

S.3.1.13. Waiver/MFP enrollment;

S.3.1.14. Court involvement/mandate type;

S.3.1.15. DCF identifier, if applicable;

S.3.1.16. Ethnicity and Race;

S.3.1.17. MMIS provider type;

S.3.1.18. MMIS provider specialty;

S.3.1.19. Provider identifiers and TIN;

S.3.1.20. Service type/level of care;

S.3.1.21. Procedure code/revenue code;

S.3.1.22. Fiscal Year or Calendar Year;

S.3.1.23. Periodic Comparison (month to month, year to year); and

S.3.1.24. Compilation by day, week, month, quarter, semiannually, and yearly.

S.4. Data Aggregation

S.4.1. The Contractor shall aggregate the data collected statewide by standard human

service regions;

S.4.2. The Contractor shall aggregate the data collected geographically by client's town of residence and provider service location. Geographic aggregation of provider data shall be based upon the provider's type, specialty and service location;

S.4.3. The Contractor shall aggregate data collected by client/medical home attribution; client/health home attribution; or client/integrated care organization attribution as such attribution methodologies are established.

S.4.4. The Contractor shall ensure that authorization data includes units denied and authorized.

S.5. Standard and Ad-hoc Reports

S.5.1. The Contractor shall produce for the Department Standard and Ad-hoc reports including those that may be required of the Department (e.g., by the legislature);

S.5.2. The Contractor shall produce Standard reports on a regularly scheduled basis as defined by the Department on all activities and measures in the format outlined in the Data Reporting Requirements section and Exhibit E, Reporting Matrix. The Department may modify the format and specifications of these Standard reports.

S.5.3. The Contractor shall produce Ad-hoc reports upon request of the Department. Ad-hoc reports may require data from any or all of the Contractor's databases associated with the contract resulting from this RFP including but not limited to the provider database, authorization database and credentialing database. The Contractor shall provide a request form that structures the Ad-hoc report request process such as by identifying report criteria, data necessary, priority, resources, and turnaround time. If the requested report exceeds staff resources, the Contractor shall work with the Department to prioritize requests in order to accommodate requested reports within available resources. If requested reports cannot be so accommodated, the Contractor and the Department shall negotiate the cost of accommodating the request.

S.5.4. The Contractor shall produce and deliver such Ad-hoc reports to the Department within five (5) business days of the Contractor's receipt of the Department's written request. If the Contractor will not be able to make the Ad-hoc report available within the requisite five (5) business days, then the Contractor shall, within three (3) business days from its receipt of the initial request, notify the Department's that of the estimated production date. The Contractor's response shall include reporting specifications, report development and resource requirements, and the expected delivery date of the information.

S.6. The Bidder Shall

S.6.1. Provide a description of the bidder's information system and its ability to meet the requirements of this section.

S.6.2. The Department recognizes that a managed care organization typically undertakes HEDIS reporting using its own claims data and that the use of the Department's MMIS claims data may present special challenges. Please describe in detail how the bidder would propose to use the Department's claims data to produce all required HEDIS reports. In its description, the bidder shall identify any challenges associated with the use of Department provided claims data for the production of HEDIS reports and any proposed resolution.

S.6.3. Review and cross-reference the reports and needed data requested in Exhibit E with its standard reports and provide a sample and/or a template of each report that matches what is being requested in Exhibit E.

S.6.4. Provide a description of procedures that the bidder will undertake to ensure the integrity of the data maintained within its information system and to assure the quality and integrity of any reports that the bidder is required to produce under the resulting Contract.

S.6.5. Provide additional reports that have been utilized by the bidder in the management of similar populations.

T. INFORMATION SYSTEM

T.1. System Requirements

T.1.1. The Contractor shall be required to transmit authorization data to the Department MMIS Contractor, integrate claims and authorization data and to produce extracts for the Department data warehouse.

T.1.2. The Contractor shall establish and maintain a HIPAA compliant computer system to accommodate all operational and reporting functions set forth herein.

T.1.3. The Contractor shall establish and maintain connectivity between the Contractor's information system and the Department's systems and to support the required eligibility data exchanges based upon the Department's standards for the exchange of data.

T.2. Eligibility Data

T.2.1. The Contractor shall accept eligibility, membership and enrollment data (eligibility data) from the Department and the Department's contractors electronically.

T.2.2. Upon receipt of the eligibility data from the Department and/or its contractors, the Contractor shall conduct a quality assurance or data integrity check of the eligibility data.

T.2.2.1. Any eligibility audit report that results in an error rate below two percent shall be loaded into the Contractor's information system within two business days of receipt.

T.2.3. The Contractor shall, in a format specified by the Department, notify it of any eligibility record that errors out due to missing or incorrect data and post corrected data to the Contractor's eligibility system.

T.2.4. The Contractor shall generate an update report that includes the number of eligibility records that have been read and the percentage of records loaded.

T.2.5. The Contractor shall provide all authorized Intensive Care Managers with on-line access to the Contractor's comprehensive eligibility database to serve members and providers.

T.2.6. The Contractor shall verify the eligibility of persons not yet showing in the monthly eligibility file utilizing PC-based software, Provider Electronic Solutions (PES), to query the Department's Automated Eligibility Verification System (AEVS).

T.2.7. The Contractor shall add a missing member to the Contractor's eligibility database as a "temporary" member if services are requested by or for an individual who is not listed on the monthly eligibility file but who is listed on AEVS.

T.3. Build and Maintain the Provider File

T.3.1. Initial Provider File Information and Updates

T.3.1.1. The Contractor shall receive an initial provider extract from the Department's MMIS contractor in a file layout and media determined by Department's MMIS and load the information into the Contractor's MIS;

T.3.1.2. The Contractor shall accept from the Department's MMIS contractor provider adds and changes to the Contractor at a frequency agreeable to the Contractor and the Department in a format and media determined by the Department and update the Contractor's MIS provider file accordingly within three business days of receipt;

T.3.1.3. The Contractor shall accept from the Department additional source provider data that it may otherwise obtain from providers and use such information to build a more comprehensive provider file; and

T.3.1.4. The Contractor shall build the provider file locally and such file shall reside on a server located in the Connecticut Service Center, unless the Contractor is able to satisfy the Department that it can comply with all of the requirements with a provider file that does not reside locally.

T.3.2. Supplemental Information

T.3.2.1. The Contractor shall customize the Contractor's MIS provider file to accommodate supplemental information required by the Department;

T.3.2.2. The Contractor shall update the Contractor's provider file to include the supplemental data elements obtained through the provider re-enrollment

process and the uniform provider application developed by the Department.

T.3.3. Provider Identification

T.3.3.1. The Contractor shall propose and implement a provider identification solution in its provider file that shall permit all authorizations to be correctly linked to the provider's CMAP ID, provider type and specialty and that will enable reporting and external provider searches by service location (address) regardless of provider type.

T.3.3.2. The Contractor shall utilize the provider's NPI, assignment type, provider type and specialty in the authorization or denial of services. This will enable reporting and external provider searches by service location (address) regardless of provider type. See Exhibit C: UM Guidelines for a complete list of proposed service categories that will require prior authorization.

T.3.4. Data Elements

T.3.4.1. The Contractor shall store the minimum provider data elements as displayed in Exhibit G Authorization File Layout v1.0 and the minimum provider data elements in the table below in the Contractor's MIS provider file.

Data Elements	
Provider Type	Clinical Specialties
Service Types	Discipline License Level
Provider ID	Provider Specialty
Location ID	Primary service location address
CMAP ID	Alternate service location address
CMAP Provider type	Service City (Primary and alternates)
CMAP Provider specialty	Service State (Primary and alternates)
Last Name	Service Zip (Primary and alternates)
First Name	Service Phone (Primary and alternates)
Middle Initial	Service Contact Name

Mailing Address 1	TIN
Mailing Address 2	Billing Address 2
Mailing City	Billing State
Mailing State	Languages Spoken
Mailing Zip	Race/Ethnicity
E-mail address	Populations served
Gender	Enrollment status
Billing Address 1	NPI
Billing City	NPI Taxonomy (Primary and 5 additional)
Billing Zip	License number

T.3.5. Other Requirements

T.3.5.1. The Contractor shall ensure that the Contractor's provider database can identify where services reside by location, provider type and specialty.

T.3.5.2. The Contractor shall ensure that provider searches can also be conducted in the Provider Subsystem, Claims Subsystem, Case Management module, and the Inquiry Tracking module.

T.3.5.3. The Contractor shall ensure that the provider subsystem supports processes involving provider entry, reports, inquiry, and other fields to meet Department requirements.

T.4. Data Extracts from the Department to the Contractor

T.4.1. The Contractor shall receive paid and denied claims extract files for their member population from the Department's MMIS Contractor.

T.4.2. The Department shall provide the Contractor with claims extracts from its MMIS contractor for each scheduled financial cycle, typically on a bi-monthly basis.

T.4.3. The claims extracts shall be used to produce claims based reports outlined in Exhibit E - Reporting Matrix including the full complement of HEDIS Medicaid measures.

T.5. Batch Authorization Files

T.5.1. The Contractor shall provide to the Department's MMIS contractor a daily Prior Authorization (PA) Transaction batch file of all authorized services and authorization updates indicating service member ID, CMAP ID, procedure/revenue code, units, span dates, diagnosis, and any other information specified by the Department's MMIS contractor. The batch file layout will be in a custom (i.e., non-HIPAA compliant) format specified by the Department's MMIS contractor.

T.5.2. The Department shall require that its MMIS contractor provide a Daily Error file to the Contractor in response to each PA Transaction file that is received from the Contractor. The Daily Error file will be sent to the Contractor on the same day that the corresponding PA Transaction file is received.

T.5.3. The PA Transaction file from the Contractor and the Daily Error file to the Contractor from the Department's MMIS contractor shall be transferred electronically via File Transfer Protocol (FTP) or other mutually agreeable and secure means of transmission.

T.5.4. The Department shall produce a "units used" file at a frequency to be determined. The Contractor shall receive and upload the units used file thus retaining a complete record in its care management system of units used against total units authorized.

T.5.5. The Department shall grant Contractor on-line access to interChange to look up authorizations resident in the interChange (iC) system, whether authorized by the Contractor, the Department or a previous contractor. The table below provides the fees for setup and weekday usage.

Fee Type	Occurrence	Services
Set-up $3,200	One-time, per organization fee at start up	Network line configuration and setup Technical support getting organization connected and tested Initial end-user Training on navigation and use of interChange application Security Setup Technical and contract documentation

User Fee $750	Annual per individual user/log-on ID	Access to the system from 7:00 am – 6 pm eastern time Monday - Friday On-going technical/business support Refresher Training (up to 3 hours annually) Administrative fees

T.6. Data Extracts from Contractor to the Department

T.6.1. The Contractor shall provide the Department with the complete provider file and authorization file as required by the Department in a format specified by the Department.

T.7. Access by the Contractor to Department's Data Warehouse

T.7.1. The Department shall train the Contractor staff to use the Department's data warehouse for inquiry and reporting. If requested by DSS the Contractor shall use the Department data warehouse to generate required ad-hoc reports directed by the Department.

T.8. Access by Department to Contractor's Databases/Data Warehouse

T.8.1. The Contractor shall provide a secure and mutually agreeable mechanism by which Department personnel can access the Contractor's reporting databases and/or data warehouse which may include but shall not be limited to access to the authorization file, the network provider file, and other information in the Contractor's MIS.

T.8.2. The Contractor shall develop procedures for granting the Department secure access through terminals at the Contractor's Connecticut service center and for training an adequate number of Department personnel in report generation and ad hoc querying. At the Department's request, the Contractor shall provide training in any ODBC compliant reporting tools used by the Contractor's reporting staff to provide reports to the Department.

T.8.3. The Contractor shall, if requested by the Department, provide a workstation, to include a personal computer with access rights to the Contractor's reporting software tools, databases and data warehouse related to the contract resulting from this RFP, at the service center for use by the Department.

T.9. Telecommunications and IT Systems Outage

T.9.1. The Contractor shall notify the Department when it experiences a telecommunications outage during normal business hours that exceeds 15

minutes.

T.9.2. The Contractor shall track all outages including date, outage duration, and outage reason of any mission critical part of its IT or telecommunications system and make this report available to the Department upon request.

T.10. Disaster Recovery and Business Continuity

T.10.1. The Contractor shall, by February 1, 2012, provide to the Department a Disaster Recovery and Business Continuity plan that will, at a minimum, prevent the loss of historical data and ensure continuous operations, meaning no break in member and provider telecommunications and authorization services of more than thirty (30) minutes in the event of a system failure and no more than five (5) business days for all other administrative functions.

T.10.2. The plan shall include a backup schedule and the Contractor's plan for responding to phone calls seamlessly in the event of local power failures, phone system failures or other emergencies.

T.10.3. During such period as the disaster recovery plan is in effect, the Contractor shall be responsible for all costs and expenses related to provision of the alternate services under its normal Administration fee. The Contractor shall notify the Contract Administrator prior to the initiation of alternate services as to the extent of the disaster and/or emergency and the expected duration of the alternate services within twenty-four (24) hours of onset of the problem.

T.10.4. The Department shall review and approve the Disaster Recovery Plan or provide the Contractor with comments and changes. The Contractor is required to advise the Department, in writing of any anticipated changes to those sections of the Contractor's Disaster Recovery Plan that have been approved by the Department.

T.10.5. The Contractor shall maintain and execute the Disaster Recovery and Business Continuity plan to ensure compliance with the Department's IT requirements even if a disaster interrupts normal business and IT operations. The Disaster Recovery or "IT Business Continuity" plan shall include:

T.10.5.1. Daily Backups

Traditional daily system backups shall be done on all servers to ensure that the content of all of both host and local area network systems can be recovered in the event of a disaster. Software and production data files are copied to digital tape or other suitable media. A verification and audit program shall be used to confirm that the system backup tapes are complete and accurate and can be properly restored. Copies of the tapes shall be created and stored in a secure off-site location to be used to reload the production systems. System backup tapes shall be rotated regularly to ensure physical integrity of the tapes and to minimize tape parity error problems;

T.10.5.2. Backup Power

A backup power generator shall support the Contractor's information systems wherever such systems shall reside and restore power to the systems within minutes in the event of a power failure. The service center computer room shall be supported with its own uninterruptible power supply to continue operations while the building backup power generator is activated;

T.10.5.3. Recovery

The Contractor shall be able to have the Contractor's IT system back online within 15 to 30 minutes and operating in a secure environment; and

T.10.5.4. Testing

Testing of the disaster recovery process, at a minimum, shall be provided for bi-annually with preparation and delivery of a report to the Department within one month of the test.

T.11. The Bidder Shall

T.11.1. Describe its information system's capability to accommodate all operational and reporting functions required in this RFP.

T.11.2. The bidder shall describe its ability to adapt its information technology systems to the needs of this contract, including but not limited to its ability to exchange data electronically, configure its data exchange mechanisms to be fully compatible with the Department's MMIS, as well as the systems used by the Department's other health care contractors. If a bidder contracts with other states or large organizations requiring large data exchanges, the bidder must clearly demonstrate to the Department that its information systems may be altered to meet the specific needs of this contract and these alterations will not be impacted by the business needs of the Contractor's other large contractors

T.11.3. The bidder is expected to conduct effective and efficient health data analytics to support health risk stratification, ICM assignment and population health management using MMIS claims data provided by the Department. The bidder shall describe whether and to what extent the bidder and its health data analytics solution can analyze data sets using data other than the bidders own claims data. The bidder shall also describe in detail how its health data analytics solution can use the Department's MMIS claims data. In its description, the bidder shall identify any challenges associated with the use of Department provided claims data for the conduct of health data analytics and any proposed resolution.

T.11.4. Describe its disaster recovery plan.

T.11.5. Describe its plan to assemble a single comprehensive eligibility database.

T.11.6. Describe its process to verify eligibility of individuals who are not listed in

the eligibility file at the time of their service request.

T.11.7. Describe its plan to assemble a single comprehensive authorization file.

T.11.8. Describe its plan to assemble a single comprehensive provider file.

U. NOTICES OF ACTION, DENIAL NOTICES, APPEALS AND ADMINISTRATIVE HEARINGS

U.1. General Requirements

U.1.1. The requirements for the content and issuance of Notices of Action and Denial Notices and the processes for Appeals to the Contractor and Administrative Hearings heard by the Department vary by program (Medicaid and Charter Oak) and may change.

U.1.2. To the extent that there are changes in state or federal law that affect these requirements or policies the Contractor shall be required to modify the processes at the direction of and with the approval of the Department.

U.2. Notices of Action and Denial Notices

U.2.1. The Contractor shall meet or exceed the Notice of Action and Denial Process Requirements as specified for each program and set forth in this Section. The Contractor shall, no later than October 15, 2011, submit to the Department for its review and approval, a Member Appeals Process including policies and procedures related to the administration of Notices of Action, Denial Notices, and internal appeals processes in accordance with this section.

U.2.2. The Contractor shall automatically generate authorization letters from its computer system whenever a request for authorization is entered. If the client denies or takes other adverse action on a request, the Contractor must tailor the explanation of and reason for the action individually for each client.

U.2.3. The Contractor shall generate Notices of Action and Denial Notices specific to each program and each type of action. For Medicaid, the Contractor shall issue notices for both denials and partial denials on the approved notice, as applicable. A partial denial includes approval of a good or service that is not the same type, amount, duration, frequency or intensity that is requested by the provider. These requests also include additional requests and/or re-authorization requests. The Contractor shall issue denial notices to Charter Oak members if the Contractor denies a provider's request for services covered under the Charter Oak benefit package, regardless of whether such determination was made before, during or after provision of the service. Notices shall be communicated in writing and sent out as expeditiously as possible, but no later than three (3) business days following the date of the decision.

U.2.4. For Medicaid, the Contractor shall issue notices for terminations, suspensions and reductions of previously authorized services, on the approved notice, as applicable. Termination/Suspension/Reduction notices related to previously authorized covered services shall be communicated in writing ten days in advance of the effective date. The ten (10) day advance notice requirements do not apply, and the Contractor may send a Notice of Action no later than the date of action in any of the circumstances described in 42 C.F.R. § 431.213. The Contractor may shorten the 10-day advance notice in the circumstances described in 42 C.F.R. § 431.214.

U.2.5. If additional information is needed for the Contractor's consideration of a request for approval of covered services for any member and the provider does not wish to participate in a peer review or is not available for peer review within the decision timeframe required of the Contractor for the pending request in accordance with subsections D.6 and D.7, then the Contractor shall issue an NOA or Denial Notice, as applicable. The notice shall state that the reason for the action is the lack of sufficient information from the provider to demonstrate medical necessity.

U.2.6. The Department shall by September 15, 2011, provide the Contractor with templates for the Notices of Action and Denial Notices required by this section. The Department shall provide templates for the following: Notice of Action pertaining to Denials/Partial Denials for Medicaid; Notice of Action pertaining to Termination, Suspension, Reduction for Medicaid; Denial Notice for Charter Oak;; Appeal/Administrative Request form for Medicaid; Appeal Application Form/DOI Instructions for Charter Oak. The Contractor shall submit final standardized Notices of Action and Denial Notices to the Department for review and approval, the format and content of which may not be altered without the prior written approval of the Department. All notices shall include the specific reason for denial in English and in Spanish.

Program	Template
Medicaid	NOA for Denials/Partial Denials
	NOA for Termination, Suspension, Reduction
	Appeal / DSS Hearing Process
	"What You Should Know"
HUSKY B	Denial Notice
Charter Oak	Appeal Application Form / DOI Instructions

U.2.7. The Contractor shall mail the applicable notice to one of the following individuals:

U.2.7.1. The member, if the member is 18 years of age or older and, if applicable, the member's conservator or guardian;

U.2.7.2. The member's head of household or member's parent or guardian if the member is under the age of 18; or

U.2.7.3. The identified person at DCF's central office for a child who is committed to or under the custody of the Department of Children and Families.

U.2.8. The Contractor shall require and advise members that the member may file an appeal in writing within sixty (60) days of the receipt of the notice on a form provided by the Department. Appeals may be filed by the member; the member's authorized representative, a conservator or guardian, or the member's parent or guardian if the member is under the age of 18. A provider may initiate a medical necessity appeal, on the provider's own behalf or on behalf of a member. The provider shall obtain a written authorization from the member for an appeal that is submitted on behalf of the member and shall retain the written authorization on file.

U.2.9. The Contractor shall track in a database all cases sent to a Peer Advisor for review, as well as the outcomes of each review. Each case sent to a Peer Advisor shall contain the clinical information the Care Manager has obtained as well as the appropriate level of care criteria and the definition of medical necessity. Daily reports shall be run from this database. Decisions to deny, partially deny, terminate, suspend or reduce services shall be entered into a database. All Notices of Action and Denial Notices, with appropriate appeals rights, shall be generated from this database. All letters shall be generated within three (3) business days of complete PA request. The notices shall follow the verbal notification of the decision to the provider in instances when the clinical circumstances require immediate response back to the provider.

U.2.10. The Contractor shall complete a quality control check on 100 percent of all Notices of Action and Denial Notices. The Quality Control Check must be performed by an individual(s) with specific training on the contractual and legal requirements for notices and processes for each of the programs. Letters generated shall be compared with the report of all cases that have been sent to a Peer Advisor to assure that letters are generated for all denials, partial denials, terminations, suspensions and reductions, within one business day of the decision. A member of the Clinical Operations management team shall review denial letters before they are mailed. Letters shall be reviewed for accuracy in format and for content against a checklist.

U.3. Continuation of Benefits Pending Appeal

U.3.1. If the Contractor terminates, suspends or reduces an existing authorization for services being provided to a Medicaid member, the member has a right to

continuation of those services, provided that the member files an appeal/hearing request within ten (10) calendar days of the date the NOA is mailed to the member, or the effective date of the intended action, whichever is later. The right to continuation of services applies to the scope of services previously authorized. The right to continuation of services does not apply to subsequent requests for approval that result in denial of the additional request or re-authorization of the request at a different level than requested.

U.4. Contractor Appeals Process – Routine

U.4.1. The Contractor shall develop and implement a timely and organized appeal process to resolve disputes between the Contractor and members concerning the Contractor's denial/partial denial, termination, suspension, or reduction of services for Medicaid members and for the denial of services for HUSKY B and Charter Oak members. Such processes shall include the development of written policies and procedures for appeals. The Contractor shall maintain a record keeping system for appeals, which shall include a copy of the appeal, the response, the final resolution and supporting documentation.

U.4.2. The Contractor shall designate one primary and one back up contact person for its appeal/administrative hearing process.

U.4.3. The process for pursuing an appeal and for requesting an administrative hearing shall be unified for Medicaid members. The Contractor and the Department shall treat the filing of a Medicaid appeal as a simultaneous request for an administrative hearing.

U.4.4. Appeals by Medicaid members shall be mailed or faxed to a single address within the Department. The Department shall

U.4.4.1. schedule an administrative hearing within thirty (30) calendar days of receipt of the appeal and notify the member and Contractor of the hearing date and location. If a member is disabled, the hearing may be scheduled at the member's home, if requested by the member.

U.4.4.2. date stamp and forward the appeal by fax to the Contractor within two (2) business days of receipt. The fax to the Contractor will include the date the member mailed the appeal to the Department. The postmark on the envelope will be used to determine the date the appeal was mailed.

U.4.4.3. fax a request for expedited review to the Contractor within one business day of receipt by the Department when the member's appeal contains a request for expedited review. The fax will include the date the member mailed the appeal. If the Contractor receives an appeal form, the Contractor shall date stamp and fax the appeal to the appropriate fax number at the Department within two (2) business days.

U.4.5. Appeals for HUSKY B or Charter Oak members shall be mailed or faxed to a single address at the Contractor. The Contractor shall date stamp the appeal upon

U.4.6. An individual(s) having final decision-making authority shall render the Contractor's appeal decision. Any appeal arising from an action based on a determination of medical necessity shall be decided by one or more Peer Reviewers who were not involved in making the medical decision related to the denial or other action. The Peer Reviewers shall have the appropriate training or clinical experience to be able to render an expert opinion on the subject of the appeal.

U.4.7. An appeal may be decided on the basis of the written documentation available unless the member requests an opportunity to meet with the individual or individuals making that determination on behalf of the Contractor and/or requests the opportunity to submit additional documentation or other written material.

U.4.8. If the member wishes to meet with the Contractor's decision-maker, the meeting can be held via telephone or at a location accessible to the member. Subject to approval of the Department's regional Offices, any of the Department office locations may be available for video conferencing.

U.4.9. The Contractor shall

U.4.9.1. attempt to resolve the appeal at the earliest point possible, but no later than thirty (30) days following the filing of the appeal.

U.4.9.2. resolve all Medicaid appeals no later than the date of the administrative hearing or within thirty (30) days of the filing of the appeal, whichever is earlier.

U.4.9.3. mail to the member, the member's conservator, the member's parent or guardian if the member is under the age of 18 and/or the DCF central office contact person for any child who is committed to or in the custody of DCF, by certified mail, a written appeal determination described below, with a copy to Department, by the date of the Department's administrative hearing for Medicaid members or within thirty (30) days of receipt of the appeal for Charter Oak members.

U.4.9.3.1. The Contractor's written appeal determination shall include the member's name and address; the provider's name and address; the Contractor's name and address; a complete description of the information or documents reviewed by the Contractor in rendering its decision; a complete statement of the Contractor's findings and conclusions, including a citation to the legal authority that is the basis of the appeal determination; a clear statement of the Contractor's disposition of the appeal; and a statement that the member has exhausted the Contractor's internal appeal procedure.

U.4.9.3.2. The appeal determination shall be responded to in the language that the appeal was submitted. For Charter Oak members, the Contractor shall also send a copy of an application form and relevant instructions on

the process for filing an appeal through the Connecticut Insurance Department (CID) external appeals process.

U.4.9.4. Along with the appeal determination, the Contractor shall remind the member on a form, which shall be approved by the Department, of the option to appeal to the Department if the member is dissatisfied with the Contractor's denial, partial denial, reduction, suspension, or termination of goods or services.

U.4.9.4.1. For Medicaid members, the form shall state that the Department has already reserved a time to hold an administrative hearing concerning that determination.

U.4.9.5. Medicaid appeal determinations shall remind the member that the Department has reserved a time for the administrative hearing and, that if the member fails to appear at the administrative hearing without good cause for failure to appeal, the member's reserved hearing time will be cancelled and any disputed services that were maintained will be suspended, reduced, or terminated in accordance with the Contractor's appeal determination. If Medicaid members are entitled to continuation of services, the Contractor shall indicate that the services will be continued for the duration of the existing authorization until the result of the Administrative hearing.

U.5. Contractor Appeals Process – Expedited

U.5.1. The Contractor shall conduct an appeal on an expedited basis if the 30-day appeal timeframe could jeopardize the life or health of the member or the member's ability to regain maximum function.

U.5.2. The postmark on the envelope or the date stamp of the fax will be used to determine the date the appeal was filed.

U.5.3. The Contractor shall determine, within one business day of receipt of an appeal that contains a request for an expedited review, whether to expedite the review or whether to perform a review according to the standard timeframes.

U.5.4. The Contractor shall expedite its review in all cases in which such a review is requested by the member's treating provider, functioning within his or her scope of practice as defined under state law, or requested by the Department.

U.5.5. An expedited review shall be completed and an appeal decision shall be issued within a timeframe appropriate to the condition or situation of the member, but no more than three (3) business days from the Contractor's receipt of the appeal from the Department or from the member, unless the member asks to meet with the decision maker or to submit additional information.

U.5.6. If the member asks to meet with the decision maker and/or submit additional information, the decision maker shall offer to meet with the member within three (3) business days of receipt of the appeal from the Department, and the Contractor

shall issue its determination not later than five (5) business days after receipt of the appeal.

U.5.7. The meeting with the member may be held via the telephone or at a location accessible to the member; subject to approval of the Department's Regional Offices any of the Department's office locations may be available for video conferencing.

U.6. Administrative Hearings-Medicaid

U.6.1. If a member is dissatisfied with the results of the appeal determination or the Contractor has not issued the appeal determination, the Department shall conduct the Administrative hearing as scheduled.

U.6.2. If a member proceeds to a hearing, the Contractor shall make its entire file concerning the member and the appeal, including any materials considered in making its determination, available to the Department.

U.6.3. The Contractor shall make available staff who are familiar with the case to attend the hearing.

U.6.4. The Contractor's file shall include a summary of the clinical justification supporting the original decision and subsequent appeal determination.

U.6.5. The Contractor shall prepare a summary for the administrative hearing, subject to approval by the Department. The Contractor shall submit a draft hearing summary seven (7) business days prior to the scheduled hearing date and a final, signed hearing summary to the DEPARTMENT and the HUSKY A Member no later than five (5) business days prior to the scheduled hearing date, and shall present proof of all facts supporting its initial action.

U.6.6. The Contractor shall present any provisions of the contract resulting from this RFP or any policies or guidelines that support its decision.

U.6.7. The Contractor shall comply with any requests for additional information made by the hearing officer during the hearing. The Contractor shall be bound by the Department's hearing decision.

U.6.8. If the Department reverses the Contractor's decision to deny, terminate, suspend or reduce services, the Contractor shall promptly authorize the disputed services, as expeditiously as the member's health requires. The Contractor shall document compliance with the hearing decision, as directed by the Department.

U.7. External Review - Charter Oak and HUSKY B

U.7.1. If a HUSKY B or Charter Oak member has exhausted the Contractor's internal appeals process and has received a final written determination from the Contractor upholding the Contractor's original denial of the service, the member may file an external appeal with the Connecticut Insurance Department ("CID") within sixty (60)

days of the receipt of the final written appeal determination. The member may be required to file a filing fee for the CID appeal. The member may be asked to submit certain information in support of his or her appeal request, including a photocopy of his or her HUSKY B or Charter Oak enrollment card. The member (or the member's legal representative) may also be asked to sign a release of medical records.

U.7.2. The CID will assign the appeal to an outside, independent entity. The reviewers will conduct a preliminary review and determine whether the appeal meets eligibility for review. The member will be notified within five (5) business days of CID's receipt of the request whether the appeal has been accepted or denied for full review.

U.7.3. The Contractor's appeal determination for a HUSKY B or Charter Oak member shall advise the member that they may file an external appeal of the denial of services with the Department of Insurance ("CID") within sixty (60) days of receipt of the final written appeal determination, as more fully described in P.7.2.

U.7.4. The Contractor shall provide a copy of the CID External Appeal Consumer Guide and an external appeal application form with a HUSKY B or Charter Oak appeal determination. The Contractor shall also advise HUSKY B or Charter Oak members that they may obtain additional information about the external review process from the CID at Connecticut Insurance Department, P.O. Box 816, Hartford, CT 06142 or (860) 297-3910 or www.ct.gov/cid - "File an External Appeal".

U.7.5. The Contractor shall comply with CID's external appeal determination.

U.8. The Bidder Shall

U.8.1. Propose the method that would be used for issuing NOAs and denials. This description shall at a minimum indicate if the process for issuing the NOA or denials will be automated or completed manually, how the NOA process will differ from the denial process and the timeframes for distribution.

U.8.2. Describe the process that would be used to ensure that all NOAs and denials are distributed in accordance with the timeframes required by the contract resulting from this RFP.

U.8.3. Propose an internal grievance and expedited appeals process.

V. PROVIDER APPEALS

V.1. General Provisions

V.1.1. A provider may lodge medical necessity and administrative appeals with the Contractor.

V.1.2. The Contractor shall, no later than December 15, 2011, submit to the Department

for review and approval a Provider Appeals Process including policies and procedures related to the administration of denial, and internal appeals processes.

V.2. Medical Necessity Appeals

V.2.1. Level One

V.2.1.1. Upon receipt of the decision from the Contractor, a provider may initiate the appeals process by notifying the Contractor verbally or in writing. The provider shall be required to initiate the appeal no later than seven (7) calendar days after receipt of the decision to deny, partially deny, reduce, suspend or terminate a health service.

V.2.1.2. The Contractor shall arrange for peer review within one (1) business day or peer desk review if the provider peer is unavailable. The Contractor shall render a determination of the appeal and notify the provider telephonically no later than one (1) hour after completion of the peer review or peer desk review. The Contractor shall mail notice of the appeal determination to the provider within two (2) business days.

V.2.2. Level Two

V.2.2.1. If the provider is dissatisfied with the first level appeal determination, the provider may initiate a second level appeal by sending written notice to the Contractor no later than fourteen (14) calendar days after the first level appeal denial. The provider must submit additional documentation in support of the appeal including the medical record within thirty (30) calendar days of the request for the appeal.

V.2.2.2. The Contractor shall send the provider notice of the determination of the second level of appeal no later than five (5) business days after receipt of information deemed necessary and sufficient to render a determination.

V.3. Administrative Appeals

V.3.1. A provider may appeal a determination by the Contractor based on non-compliance by the provider with policies and procedures pertaining to utilization management.

V.3.2. The provider may, no later than seven (7) calendar days after receipt of the determination from the Contractor, initiate an administrative appeal by providing the Contractor with a rebuttal with additional information or good cause.

V.3.3. The Contractor shall mail a notice of the determination to the provider within seven (7) business days following receipt of the appeal. The notification shall include the principal reason for the determination and instructions for requesting a further appeal, if applicable.

V.4. Outcome of Appeal

V.4.1. If the appeals process is followed and the denial determination is overturned, the Contractor shall authorize services to allow for provider payment for covered services rendered to a member.

V.4.2. If the appeals process is not followed or if the appeals process is followed and the appeal is denied, the Contractor shall not authorize provider payment for the services that are the subject of appeal.

W. SECURITY AND CONFIDENTIALITY

W.1. Compliance with State and Federal Law

W.1.1. The Department is required by state and federal law to protect the privacy of applicant and client information.

W.1.2. The Department is a "covered entity," as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), more specifically with the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C, and E.

W.1.3. Accordingly, the Contractor shall be required to comply with these and all other state and federal laws concerning privacy and security of all client information provided to the Contractor by the Department or acquired by the Contractor in performance of the contract. This includes all client information whether maintained or transmitted verbally, in writing, by recording, by magnetic tape, or electronically.

W.1.4. Compliance with privacy laws includes compliance with the HIPAA Privacy Rule and also compliance with other federal and state confidentiality statutes and regulations that apply to the Department. The Department also requires the Contractor to continually update and improve its privacy and security measures as client data becomes more vulnerable to external technological developments.

W.1.5. The Contractor shall comply with state and federal privacy law as an agent of the Department and comply with the HIPAA Privacy Rule (federal regulations) as a "business associate" of the Department.

W.1.6. The Contractor shall comply with state security laws as an agent of the Department and comply with the HIPAA Security Rule (compliance date April 20, 2005) as a "business associate" of the Department.

W.1.7. The Contractor shall maintain and store information and records in accordance with state and federal laws and record retention schedules.

W.2. Staff Designation

W.2.1. The Contractor shall designate the Contractor's MIS Director to serve as the local

Security and Privacy Officer, responsible for implementation and monitoring of compliance with privacy and security policies and procedures and for reporting any security or privacy breaches.

W.2.2. The Department shall designate and notify the Contractor of the specific staff authorized by the Department to access and request client information from the Contractor in order to maintain the security and confidentiality of applicant and client information.

W.2.3. The Department shall review and approve all Contractor staff that will have access to the Department's data warehouse on either a routine, periodic, or ad hoc basis.

W.3. Security and Privacy Plan

W.3.1. The Contractor shall develop a local Security and Privacy Plan with policies and procedures that comply with state and federal law concerning the use, disclosure, and security of client data in order to maintain the security and confidentiality of applicant and client information.

W.3.2. The Contractor shall submit the Security and Privacy Plan to the Department for review and approval by November 15, 2011.

W.3.3. The Contractor's Security and Privacy Plan shall be consistent with state and federal laws that pertain to the Department and shall address, at a minimum, the following topics:

W.3.3.1. Preventing privacy and security breaches by:

W.3.3.2. Implementing steps to prevent the improper use or disclosure of information about clients and subcontractors;

W.3.3.3. Training all employees, directors, and officers concerning state and federal privacy and security laws;

W.3.3.4. Requiring that each employee or any other person to whom the Contractor grants access to client information under the contract resulting from this RFP sign a statement indicating that he or she is informed of, understands, and will abide by state and federal statutes and regulations concerning confidentiality, privacy and security;

W.3.3.5. Limiting access to client information held in its possession to those individuals who need client information for the performance of their job functions and ensuring that those individuals have access to only that information that is the minimum necessary for performance of their job functions;

W.3.3.6. Implementing steps to ensure the physical safety of data under its control by using appropriate devices and methods, including, but not limited to, alarm

systems, locked files, guards or other devices reasonably expected to prevent loss or unauthorized removal of data;

W.3.3.7. Implementing security provisions to prevent unauthorized changes to client eligibility files;

W.3.3.8. Implementing steps to prevent unauthorized use of passwords, access logs, badges or other methods designed to prevent loss of, or unauthorized access to, electronically or mechanically held data. Methods used shall include, but not be limited to, restricting system and/or terminal access at various levels; assigning personal IDs and passwords that are tied to pre-assigned access rights to enter the system; restricting access to input and output documents, including a “view-only” access and other restrictions designed to protect data;

W.3.3.9. Complying with all security and use requirements established by the Department for parties using EMS, AEVS, or any other system, if applicable, including the signing of confidentiality forms by all employees and personnel working for subcontractors who have access to client eligibility data;

W.3.3.10. Complying with the requirement of the HIPAA privacy and security regulations that apply to business associates of the Department, including, but not limited to, returning or destroying all client information created or received by the Contractor on behalf of the Department, as directed by the Department;

W.3.3.11. Monitoring privacy and security practices to determine whether breaches have occurred;

W.3.3.12. Developing systems for managing the occurrence of a breach, including but not limited to:

W.3.3.12.1. Review of breaches in privacy and security that have been reported to them by the Contractor;

W.3.3.12.2. A system of sanctions for any employee, subcontractor, officer, or director who violates the privacy and security policies;

W.3.3.12.3. A system to ensure that corrective action occurs and mechanisms are established to avoid the reoccurrence of a breach; and

W.3.3.12.4. Practices established to recover data that has been released without authorization.

W.4. Security or Privacy Breaches

W.4.1. The Contractor shall notify the Department, in writing by the next business day upon receipt of knowledge, that an employee, director, officer or subcontractor has:

W.4.1.1. Improperly disclosed client information or improperly used, copied or

removed client data; or

W.4.1.2. Misused or used without proper authorization, an operator password or authorization numbers, whether or not such use has resulted in fraud or abuse.

W.5. Requests for Personal Healthcare Information

W.5.1. The Contractor shall notify the Department, in writing, and consult with the Department by the next business day, of the existence of:

W.5.1.1. A subpoena that has been served on the Contractor related to the Contract; or

W.5.1.2. A request made pursuant to the state Freedom of Information Act (Conn. Gen. Stat. 1-200, et seq.) received by the Contractor concerning material held by the Contractor related to the contract.

W.6. The Bidder Shall

W.6.1. Provide its plan for implementing security and protecting the confidentiality of client data.

W.6.2. Describe methods used to identify breaches.

W.6.3. Describe process for notifying the Department when a breach has occurred and the steps the Contractor will take to resolve breaches and recover unauthorized release of information.

W.6.4. Describe safeguards for protecting data that may be exchanged over the Internet.

W.6.5. Provide a copy of confidentiality and security statement and criteria for identifying those individuals who will be required to sign the statement.

X. CONTRACT COMPLIANCE, PERFORMANCE STANDARDS, AND SANCTIONS

X.1. General Requirements

X.1.1. In an effort to ensure continued quality service, the Department has established specific Performance Standards that shall be met by the Contractor. All provisions for Performance Standards described under this section shall also constitute independent requirements under the contract resulting from this RFP in addition to operating as standards for the purpose of determining whether the Contractor may be subject to penalties. In addition to sanctions related to specific Performance Standards, the Department reserves the right to impose sanctions for other conduct of the ASO, including monetary sanctions for: failure to adhere to Medicaid or other applicable program requirements, acts or omissions that could result in harm to a Member, and other conduct the constitutes noncompliance with

the Contractor or state or federal regulatory requirements.

X.1.2. Failure to meet these Performance Standards will result in a sanction against the Contractor for each occurrence per Performance Standard not met. If the Contractor's Performance Reports or Audits by the Department indicate that the Contractor failed to meet these Standards within the specifications under consideration, the Department shall adjust the Contractor's payment by a predetermined dollar amount set for each Performance Standard.

X.1.3. The Reporting Matrix in Exhibit E and deliverable due dates specified in Section V comprise all Performance Standards and corresponding measures and the dollar amount to be deducted from the Contractor's payment each time the Performance Standard is not met.

X.1.4. The Contractor shall not be penalized for reporting delays that are a consequence of delays that are the fault of the Department or their agents.

X.2. Responsibilities of the Department

X.2.1. The Department shall regularly review the Performance Standard reports to determine if the Contractor is meeting these Standards and issue a written sanction notification for each occurrence in which the Contractor fails to meet a Performance Standard. The Department shall have the sole authority to determine whether the Contractor has met, exceeded or fallen below any or all of the Performance Standards.

X.2.2. The Department shall adjust the Contractor's payment for each sanction to be paid within thirty (30) business days of the postmark date of the written sanction notification from the Department to the Contractor.

X.2.3. The Department shall review and approve the development of, modification to and implementation of corrective action plans.

X.3. Responsibilities of the Contractor

X.3.1. The Contractor shall provide the required reports as indicated in Exhibit E. Failure to provide the Department with these reports may, at the Department's discretion, be considered a failure to meet the corresponding standard.

X.3.2. Within fifteen (15) business days of the date of the Department's written sanction notification to the Contractor for failure to meet a specified standard, the Contractor shall submit to the Department a corrective action plan to avoid the reoccurrence of non-compliance and possible additional penalties and a timetable for implementation of the corrective action plan to the Department for review.

X.3.3. In determining the Contractor's compliance and achievement against the Performance Standards, performance measures shall not be rounded. For example, if the Contractor is required to achieve a performance level of 95%, the target will not be achieved if the performance is 94.9%. Where applicable all times

are measured as of Contractor's receipt of complete, legible, and accurate information.

X.3.4. Implementation of any sanction provision or the decision of the Department to refrain from implementation shall not be construed as anything other than as a means of further encouraging the Contractor to perform in accordance with the terms of the contract.

X.3.5. Implementation of a sanction provision is not to be construed as the Department's sole remedy or as an alternative remedy to the specific performance of the contract requirement and/or injunctive relief.

X.4. Alternative Effort Determination

X.4.1. The Department may provide or procure the services reasonably necessary to cure a default by the Contractor if, in the reasonable judgment of the Department:

X.4.1.1. A default by the Contractor is not so substantial as to require termination;

X.4.1.2. Reasonable efforts to induce the Contractor to cure the default are unavailing; and

X.4.1.3. The default is capable of being cured by the Department or by another resource without unduly interfering with continued performance by the Contractor.

X.5. Alternative Effort Implementation

X.5.1. If the Department exercises its right to procure services to cure the default, the Contractor's next payment will be adjusted to recover the reasonable cost of the procured services and the costs associated with the procurement of the services. If the Department exercises this right, the Contractor shall:

X.5.1.1. Cooperate with such entities the Department may obtain to cure the default and shall allow those entities access to the facility, documentation, software, utilities and equipment.

X.5.1.2. Remain liable for all system support and administration performance criteria, maintenance of and further enhancements to any applications developed by these resources to the extent that it constitutes the Contractor's work product whether impacted by the work of the other resource or not.

Y. PERFORMANCE TARGETS AND WITHHOLD ALLOCATION

Y.1. General Provisions

Y.1.1. The Department shall withhold 7.5% of each quarterly administrative payment during each year of the contract to be paid to the Contractor, in whole or in part, at the end of each contract year contingent upon the Contractor's success in meeting

Y.1.2. The established Performance Targets are tied to objectives such as access, quality, and expenditures. Each Performance Target has a separate value and, in some cases, separate values have been established for domains within each Performance Target. The Contractor shall have the opportunity to separately earn the amount associated with each Performance Target and, wherever specified in Exhibit A, each domain within each Performance Target. The established Performance Targets shall be reviewed on an annual basis before the start of the new contract year and may be revised.

Y.1.3. The Department shall measure the Contractor's success in meeting the Performance Targets. The Department shall establish specifications mutually agreeable to the Department and the Contractor for measurement of the Contractor's performance and shall calculate the Contractor's performance or base its calculation on reports or data submitted by the Contractor.

Y.1.4. The Contractor's failure to provide the Department with the requisite data or reports in accordance with the reporting frequency identified in Exhibit E shall result in the Contractor's forfeiting of the specified percentage of withhold attached to the corresponding Performance Target(s), if any.

Y.1.5. The Department shall determine whether the Contractor has met, exceeded or fallen below any or all of the required Performance Targets set forth in this subsection. The decision of the Department shall be final.

Y.1.6. In determining the Contractor's success in meeting the agreed upon Performance Targets, performance measures will not be rounded. For example, if the Contractor is required to achieve a performance level of 95%, the target will not be achieved if the performance is 94.9%.

Y.1.7. When a Performance Target includes the performance of a random sample, the sample size will be mutually agreed upon by the Department and the Contractor and will be based on the size of the population relevant to the Performance Target. The measure will be calculated and planned to enable statistically valid survey results at a 95% confidence interval with a margin of error of five (5) percentage points unless otherwise mutually agreed upon by the Department and the Contractor.

Y.1.8. The reporting period for purpose of calculation of Contractor's success in meeting the Performance Targets shall be by calendar year unless otherwise noted. Claim based reports will not be completed until nine (9) months following the close of the calendar year to allow for claims run out.

Y.1.9. The Department shall notify the Contractor of its success or failure in meeting the Performance Targets.

Y.1.10. If the Contractor has failed to meet a Performance Target the Contractor shall, within fifteen (15) business days of the date of the Department's notification

of the Contractor's failure to meet a specified Performance Target(s), submit a written report to the Department that shall explain why specific Performance Targets were not met and describe a plan of action to be implemented in an effort to meet these Performance Targets.

Y.1.11. If the Contractor has met or exceeded the Performance Targets the Department shall return the specified portion of the withhold, no later than the end of the second quarter following the end of the calendar year unless otherwise agreed to by the parties.

Y.1.12. In the case of the Contractor's success in meeting a Performance Target for claims based reporting, the Department shall also return the portion of the withhold no later than the second quarter after the close of the calendar year if the preliminary calculation of the Contractor's performance suggests that the target will be met. However, the Department shall provide a reconciliation and adjust the withhold allocation as necessary within twelve (12) months after the close of the calendar year.

Y.2. The Bidder Shall

Y.2.1. Propose its plan to address the performance areas proposed as Performance Targets as outlined in the Reporting Matrix at Exhibit E.

Y.2.2. Suggest additional targets that have been useful in other programs and are not already contained in Exhibit E.

Z. TRANSITION REQUIREMENTS

Z.1. General Provisions

Z.1.1. The Department is committed to a smooth transition to the Contractor. The start-up phase begins at contract execution and ends on at 12:01 am January 1, 2012, at which time the Contractor will assume responsibility for managing health benefits for all members.

Z.1.2. The Department shall notify all eligible members of the new administrative requirements associated with the ASO.

Z.1.3. The Department shall provide a complete authorization file as of the date of implementation.

Z.1.4. The Department shall notify all providers about the new administrative requirements under the ASO including requirements related to the transition of authorizations.

Z.2. Contractor Responsibilities

Z.2.1. The Contractor shall manage all services agreed upon in the Contract regardless

of date of admission or intake, on the date of implementation.

Z.2.2. The Contractor shall accept an extract of open authorizations from the Department.

Z.2.3. The Contractor shall conduct training sessions with providers as described in the "Provider Relations" Section on a schedule and at locations approved by the Department. The Contractor shall respond to provider questions and make best efforts to assure that providers are aware of the need to obtain necessary authorizations and associated procedures.

Z.2.4. The Contractor shall propose a plan for authorizing services that providers failed to prior authorize and to educate those providers about the UM procedures, during a transition period.

Z.2.5. The Contractor shall create a provider file as described in the subsection pertaining to Provider Network.

Z.3. The Bidder Shall

Z.3.1. Provide a plan to conduct training sessions with providers to review UM requirements and procedures and otherwise facilitate a smooth transition.

Z.3.2. Provide a plan for the safe and appropriate transition of individuals who require continued treatment, but who are receiving services from providers that are not enrolled as a provider in the Connecticut Medical Assistance Program (i.e., current HUSKY network or out-of-network providers).

Z.3.3. Propose a plan for authorizing services for which providers failed to obtain prior authorization and to educate those providers about the UM procedures, during a transition period, not to exceed three (3) months. This provision shall not exempt the service and retro-authorization from medical necessity requirements.

AA. CONTRACT IMPLEMENTATION, REVIEW AND TERMINATION PROVISIONS

AA.1. Implementation Plan

AA.1.1. The Department shall engage in good faith negotiations to execute a contract by August 1, 2011.

AA.1.2. The Contractor shall develop and provide to the Department for review and approval an Implementation Plan prior to the execution of the contract using software such as Microsoft Project, GANTT chart, or equivalent, which shall at a minimum include the designated individuals responsible for the execution of the Implementation Plan, the date by which the Contractor will begin operation of its administrative services and be responsible for managing health services for all eligible members.

AA.1.3. The Department shall prior to September 1, 2011 review the Contractor's

Implementation Plan and periodic updates and not unreasonably withhold approval of the Plan and updates.

AA.1.4. The Contractor shall perform administrative services and become operational as defined in the detailed and negotiated Implementation Plan by the date indicated in the Contractor's approved Implementation Plan, or on such other date as the Contractor and the Department may agree in writing.

AA.1.5. The Department require a fully operational health administrative system as of 12:01 am on January 1, 2012 and for each day of the contract period thereafter. The failure of the Contractor to pass the "Implementation Review" or the failure of the Contractor to provide an operational system as of 12:01 am on January 1, 2012, as agreed by the Department, in accordance with the Contractor's Implementation Plan, or the failure of the Contractor to maintain a fully operational system thereafter will cause considerable harm to the Department and their eligible members.

AA.1.6. The Department requires the timely completion of key deliverables summarized in Exhibit B and elsewhere in the contract. Failure by the Contractor to deliver each deliverable to the Department by the required due date shall results in a $1,000 sanction per late deliverable per day.

AA.2. Performance Bond or Statutory Deposit

AA.2.1. The Contractor shall be liable to the Department for resulting harm if the Contractor is not operational by the date specified in the Contractor's approved Implementation Plan. The Contractor shall not be liable for such harm if the Department has failed to meet its obligations under the contract resulting from this RFP and that failure of the Department was a material cause of a delay of the Contractor's ability to perform its administrative services by the date specified in the Contractor's approved Implementation Plan.

AA.2.2. To mitigate such harm the Department requires the Contractor to obtain either a Performance Bond or a Statutory Deposit as further described below.

AA.2.3. The Contractor shall obtain a Performance Bond or Statutory Deposit Account in the amount of $1,000,000 on or before the execution of the Contract in accordance with the following:

AA.2.3.1. The purpose of the bond or Statutory Deposit amount is to mitigate harm caused by any failure of the Contractor to perform services required in the resultant contract.

AA.2.3.2. The bond shall be provided by an insurer, which has been previously approved by the Department.

AA.2.3.3. The bond shall name the State of Connecticut as the Obligee.

AA.2.3.4. The bond or Statutory Deposit amount shall remain in effect until the latter

of:

AA.2.3.4.1. The duration of the contract and any extensions to the contract.

AA.2.3.4.2. The work to be performed under the contract has been fully completed to the satisfaction of the Department.

AA.3. Implementation Review

AA.3.1. The Department shall conduct an Implementation Review the purpose of which will be to determine whether the Contractor has achieved sufficient implementation progress to operate its administrative services by such time as indicated in the Contractor's approved Implementation Plan.

AA.3.2. The Department shall conduct this Implementation Review at least 30 days prior to the date by which the Contractor will begin to operate its administrative services as indicated in the Contractor's approved Implementation Plan.

AA.3.3. The Department shall notify the Contractor in writing of the results of its review within five (5) business days of the review. The Department may approve the Contractor's progress without comment, conditionally approve the Contractor's progress with additional requirements, or may determine that the Contractor has not made sufficient progress to operate its administrative services by the date indicated in the Contractor's approved Implementation Plan.

AA.3.4. If the Department determines that the Contractor has failed to make sufficient progress to become operational and to perform administrative services by the date indicated in the Contractor's approved Implementation Plan, the Contractor shall have five (5) business days from the date of such notice to propose a corrective action plan to the Department's satisfaction.

AA.3.5. In addition and irrespective of the Contractor's corrective action, the Department at its option may take such additional steps as they deem necessary to provide seamless delivery of health administrative services for its clients including, but not limited to, calling for execution of the Performance Bond and terminating the Contract for the Contractor's failure to pass the Implementation Review.

AA.4. Annual Performance Review

AA.4.1. The Department shall objectively evaluate the on-going performance of the Contractor during the term of the contract through annual Performance Reviews, the first of which shall be conducted within 120 days of implementation.

AA.4.2. The Department shall exercise their right to invoke the provisions of Termination subsection, when it determines the Contractor has failed to perform.

AA.5. Termination Provisions

AA.5.1. All terminations shall be effective at the end of a month, unless otherwise specified in this Article. The Contractor may be terminated under the following circumstances:

AA.5.1.1. By mutual written agreement of the Department and the Contractor upon such terms and conditions as they may agree;

AA.5.1.2. By the Department for convenience, upon not less than one hundred-eighty (180) days written notice to the Contractor;

AA.5.1.3. By the Department, for cause, upon failure of the Contractor to materially comply with the terms and conditions of the contract resulting from this RFP. The Department shall give the Contractor written notice specifying the Contractor's failure to comply and shall provide Contractor a period of thirty (30) days to cure such breach. If the Contractor fails to comply, the Department may serve written notice stating the date of termination and work stoppage arrangements, not otherwise specified in the contract resulting from this RFP. Such date of termination shall be no less than thirty (30) days following the date on which notice is provided to the Contractor.

AA.5.1.4. By the Department, in the event of default by the Contractor, which is defined as the inability of the Contractor to provide services, where such inability is not otherwise excused pursuant to the contract resulting from this RFP, described in the contract resulting from this RFP or the Contractor's insolvency. With the exception of termination due to insolvency, the Department shall require the Contractor to cure the default within thirty (30) days or to submit a plan of correction acceptable to the Department unless such opportunity would result in immediate harm to members, or the improper diversion of Medicaid program funds;

AA.5.1.5. By the Department, in the event of notification by the Connecticut Insurance Department or other applicable regulatory body that the certificate of authority under which the Contractor operates has been revoked, or that it has expired and shall not be renewed;

AA.5.1.6. By the Department, in the event of notification that the owners or managers of the Contractor, or other entities with substantial contractual relationship with the Contractor, have been convicted of Medicare or Medicaid fraud or abuse or received certain sanctions as specified in Section 1128 of the Social Security Act;

AA.5.1.7. By the Department, in the event it determines that the health or welfare of consumers is in jeopardy should the contract continue. For purposes of this paragraph, termination of the contract requires a written finding by the Department that a substantial number of members face the threat of immediate and serious harm;

AA.5.1.8. By the Department, in the event of the Contractor's failure to comply with the Scope of Work. The Contractor shall be given fourteen (14) days to cure

any such failure, unless such opportunity would violate any federal law or regulation;

AA.5.1.9. By the Department, in the event a petition for bankruptcy is filed by or against the Contractor;

AA.5.1.10. By the Department, if the Contractor fails substantially to authorize medically necessary items and services that are required under the contract resulting from this RFP;

AA.5.1.11. By the Department, if the Contractor intentionally misrepresents or falsifies information that is furnished to the Secretary of Health and Human Services, the Department or Medicaid clients, potential clients or health care providers under the Social Security Act or pursuant to the contract resulting from this RFP;

AA.5.1.12. By the Contractor, on at least thirty (30) days prior written notice in the event the Department fails to pay any amount due the Contractor hereunder within thirty (30) days of the date such payments are due; and

AA.5.1.13. By the Contractor, on sixty (60) days' written notice with cause, or one hundred eighty (180) days written notice without cause.

AA.5.2. Unless termination occurs pursuant to any of the above conditions, the contract resulting from this RFP shall terminate on the Expiration date. The Contractor shall be paid solely for covered services provided prior to the Expiration or Termination date. The Contractor is obligated to cooperate fully with the closeout or transition of any activities so as to permit continuity in the administration of the Department's programs. This includes, but is not limited to, allowing the Department's full access to the Contractor's facilities and records to the extent necessary to arrange for the orderly transfer of contracted activities (including information for the reimbursement of any outstanding Medicaid claims) and any other provisions specifically defined in the termination agreement.

AA.5.3. If the Department terminates the contract resulting from this RFP pursuant to this Article and unless otherwise specified in this Article, the Department shall provide the Contractor written notice of such termination at least sixty (60) days prior to the effective date of the termination, unless the Department itself receives less than sixty (60) days notice, in which case the Department shall provide the Contractor with as much notice as possible. If the Department determines a reduction in the scope of work is necessary, it shall notify the Contractor and the parties shall proceed to amend the contract resulting from this RFP pursuant to its provisions. By termination pursuant to this Article, neither party may nullify obligations already incurred for performance of services prior to the date of notice or, unless specifically stated in the notice, required to be performed through the effective date of termination. Any agreement or notice of termination shall incorporate necessary transition arrangements if such arrangements are not otherwise specified in the contract resulting from this RFP.

AA.5.4. In the event that either party seeks early termination of this agreement, the Contractor and the Department shall negotiate an early termination agreement that may include transition activities, the status of the Contractor during the termination/transition period, cost recovery, payment terms, and any other matter that is necessary for the orderly termination and transfer of activities to a new Contractor or the Department. Such agreement shall be concluded within thirty (30) days of the notice of termination. If agreement is not reached regarding the termination agreement within the specified thirty (30)-day period, the contract shall terminate thirty (30) days thereafter.

AA.6. The Bidder Shall

AA.6.1. Provide a written assurance to the Department, that if selected, it will engage in good faith negotiations to execute a contract by August 1, 2011 and provide a fully operational system on January 1, 2012 and will maintain a fully operational system thereafter.

AA.6.2. Provide samples of previously used Implementation Plans and corresponding project plans that show the full scope of work required to implement a contract of this size. Describe the experience of the contractor's staff responsible for carrying out implementations of this size and scope. At a minimum identify the number of times that each of these individuals has executed a public sector account of similar proportion.

BB. STAFFING, RESOURCES AND PROJECT MANAGEMENT

BB.1. Key Personnel

BB.1.1. The Contractor certifies that all key positions agreed upon in the Contract shall continue for the duration of the Contract. No changes, substitutions, additions or deletions, whether temporary or permanent, shall be made unless approved in advance by the Department, which approval shall not be unreasonably withheld.

BB.1.2. All personnel filling the key positions shall continue for the duration of the Contract. No changes, substitutions, additions or deletions, whether temporary or permanent, shall be made unless approved in advance by the Department, which approval shall not be unreasonably withheld. In the event of resignation, death or approved substitution of personnel filling the key positions, substitute personnel shall be named by the Contractor on a permanent or interim basis and approved by the Department. The Contractor shall, upon request, provide the Department with a resume for any member of its personnel or of a subcontractor's personnel assigned to or proposed to be assigned to fill a key position under the Contract. Substitutions shall be made within ten (10) Business Days of the resignation or death of personnel filling a key position, unless otherwise agreed to in writing by the Department and the Contractor.

BB.1.3. The Department reserves the right to approve or reject the Contractor's or any subcontractor's personnel assigned to the Contract, to approve or reject any proposed changes in personnel, or to require the removal or reassignment of any

Contractor personnel or subcontractor personnel assigned to the contract resulting from this RFP found unacceptable by the Department.

BB.1.4. The Contractor's Project Manager shall immediately notify the Department' Contract Managers of the discharge of any personnel assigned to the contract resulting from this RFP and such personnel shall be immediately relieved of any further work under the contract resulting from this RFP.

BB.2. Project Management

BB.2.1. From the time of the Department's approval of and throughout the term of the contract, the Project Manager will be responsible for the implementation and management of the project, for ensuring the performance of duties and obligations under the contract, the day to day oversight of the project and be available to attend all project meetings at the request of the Department. The Project Manager shall be permanently located in the Contractor's Connecticut office and shall respond to requests by the Department for status updates and ad hoc and interim reports.

BB.3. Implementation Team

BB.3.1. The Implementation Team shall:

BB.3.1.1. Organize initial and subsequent planning meetings with the Department;

BB.3.1.2. Facilitate communications between the Contractor and the Department;

BB.3.1.3. Meet with providers;

BB.3.1.4. Participate in the initial account operations following the completion of the implementation until responsibilities have been transitioned to the Project Manager and staff;

BB.3.1.5. Oversee site selection, build-out, furnishing and equipping for operation of the Connecticut Service Center; and

BB.3.1.6. Remain primarily responsible for the conduct of the implementation until such time as the Department approves the Project Manager and the transition of the implementation team's responsibilities to the Project Manager and staff.

BB.3.2. The Implementation Team shall be comprised of individuals approved by the Department.

BB.4. Staffing Levels – Ongoing Operations

BB.4.1. By November 1, 2011 the Contractor shall provide the Department with an organizational chart for the Connecticut Service Center identifying the number and type of personnel in each department and personnel category. The Contractor shall provide the Department with an updated organizational chart each time

changes are made to the number, type and/or category of personnel.

BB.4.2. The Contractor certifies that the Connecticut Service Center shall staff to conduct UM for services designated by the Department. The services include, but may not be limited to those presented in Exhibit D.

BB.4.3. For the first year of operations the Contractor's budget, approved by the Department, includes UM staffing necessary to comply with the scope of work under the contract resulting from this RFP. The number of prior authorizations, concurrent reviews and associated level of staffing shall be reviewed by the Contractor and the Department and, if necessary, adjusted in subsequent years for changes to actual enrollment, and if applicable, changes to the scope of work set forth in the contract resulting from this RFP.

BB.4.4. The Contractor shall ensure that the Contractor's staff participating in the conduct of UM, including but not necessarily limited to Care Managers and Intensive Care Managers, on average meet the following minimum productivity and efficiency standards at the Connecticut Service Center:

BB.4.4.1. That clinical support staff shall perform a variety of non-clinical functions to increase the productivity of Care Managers and Intensive Care Managers;

BB.4.4.2. That the Contractor's MIS accepts and processes registrations entered on the IVR and via the Web automatically, therefore staff time is not required;

BB.4.4.3. That authorization letters are generated automatically and therefore, staff time is not required;

BB.4.4.4. That prior authorizations for all levels of care will take approximately twenty (20) minutes each and that on average an office-based Care Manager can conduct eighteen (18) prior authorizations in an average workday. An average work day assumes that 5.5 hours of each work day that is allocated to telephonic reviews and the balance to clinical rounds, staff meetings, directing the work of clinical support staff and related administrative responsibilities;

BB.4.4.5. That Care Managers can, on average, conduct approximately 22 concurrent reviews per day, assuming an average duration of ten to fifteen minutes per call and an average of 5.5 hours per day in telephonic reviews; and

BB.4.4.6. That Intensive Care Managers will spend a significant amount of their time traveling and working in their assigned local areas, which will reduce the number of prior authorizations and concurrent reviews that they will conduct. Intensive Care Coordinators will, however, be responsible for the reviews of those members on their own caseloads.

BB.4.5. ICM clinicians will serve a defined caseload. At any given time the needs of the network or membership may dictate the necessity to change from a facility, systems focus to a member specific focus, or a combination of both. The

BB.4.5.1. ICM clinicians assigned to facilities as well as cases will be expected to carry, during a 3 month period on average a minimum of thirty (30) cases and on average, an annual minimum caseload of (120) one hundred and twenty. Facility ICM clinicians have a variety of additional administrative duties and functions not experienced by ICM clinicians with a caseload dedicated to individual member care only. These responsibilities include but are not limited to: Regular travel to assigned facilities, minute taking, case summary for all ASO cases reviewed at a facility, discharge planning for all cases on the unit, triage and communication to multiple DCF Area Office's, Emergency Department meetings as requested, and additional meetings in the community. In addition, at the discretion of the Contractor and within available Contract funds, ICM's may be assigned on call mobile responsibility to assigned facilities during high volume periods (i.e., periods of seasonal volume surge in high volume Emergency Department);

BB.4.5.2. ICM clinicians not assigned a facility will be expected to carry on average a minimum caseload of 35 members during a 3 month period and on average an annual minimum of 130 cases. In addition to managing individual cases these clinicians will serve as the ASO liaisons at Emergency Department meetings as requested, collaterals meetings and treatment and discharge planning meetings;

BB.4.5.3. Total individuals served on an annual basis shall be no less than 1400 individuals, no less than1,200 of whom will be adults; and

BB.4.5.4. The Contractor certifies that the staffing for quality management shall be sufficient to ensure that the Quality Management Department can continuously meet the requirements established in the Quality Management section of the Contract.

BB.4.6. The Contractor certifies that the staffing levels for Management Information Systems (MIS) functions include at least two (2) full time programmers who will be dedicated to customizing the Contractor's MIS for the CT BHP and designing and producing reports.

BB.4.7. The Contractor certifies that the staffing levels for the Telephone Call Management Center functions shall be based on the following assumptions:

BB.4.7.1. That upon implementation, the Contractor shall be staffed to handle call volumes based on member numbers referenced in this RFP, adjusted in subsequent months and years for increases in actual enrollment;

BB.4.7.2. That the Contractor has provided for hiring and training temporary staff as necessary to meet the increased demand during the early weeks of the

program;

BB.4.7.3. That Telephone Call Center staff shall not be responsible for responding to inquiries related to claims issues that are outside of the scope of their obligations under the Contract but shall transfer those calls to the Department's fiscal agent;

BB.4.7.4. That, based on average talk time, the Call Center service representatives can on average respond to a minimum of eight (8) calls per hour; and

BB.4.7.5. That the crisis line is set up as a separate call distribution queue with several layers of backup to ensure that there are no delays or abandoned calls.

BB.5. Staff and Infrastructure Location

BB.5.1. The Contractor agrees to locate and maintain its Connecticut Service Center including staff and infrastructure used to carry out the program/operations/services authorized by the contract resulting from this RFP within a twenty (20) mile radius of the city of Hartford, Connecticut.

BB.6. Utilization of Minority Business Enterprises

BB.6.1. Pursuant to Section 4a-60g(b) of the Connecticut General Statutes, the Department is required to set-aside at least twenty-five percent (25%) of all contracts for small contractors and/or minority business enterprises. To assist the Department the Contractor agrees to use its best efforts consistent with Section 45 CFR 74.161 and Section 4a-60g of the Connecticut General Statutes to utilize a small Contractor and/or minority business enterprise as defined in Sections 4a-60(g)(1) and (3) of the Connecticut General Statutes as a supplier of goods and services or in the award of any subcontracts which may be permitted pursuant to the contract resulting from this RFP. The Contractor shall report the status of these efforts, including but not limited to the actual dollar value and payments to small contractors and/or minority business enterprises, in a form and frequency agreed to by the Department and the Contractor.

SECTION VI: PROPOSAL EVALUATION

A. Evaluation of Proposals Objectives

A.1. The Department will conduct a comprehensive, fair and impartial evaluation of proposals received in response to this competitive procurement effort.

B. Evaluation Organization

B.1. An Evaluation Team has been established to assist the Department in selection of a Contractor.

B.2. The Department reserves the right to alter the composition of this Team.

B.3. The Evaluation Team will be responsible for the review and scoring of all proposals. This group will be responsible for the recommendation to the Commissioner. The Commissioner will notify the selected bidder(s) that the organization(s) has been awarded the right to negotiate a contract with the Department for this project.

C. Evaluation Phases:

C.1. The evaluation will be conducted in four phases:

C.1.1. Phase 1 - Evaluation of Section IV, Part One – The Minimum Requirements

C.1.2. Phase 2 - Evaluation of Section IV, Parts Two and Three – The Scope of Work, The Organization, Project Management, and Key Personnel

C.1.3. Phase 3 - Evaluation of Section IV,

C.1.4. Part Four– The Business Proposal

C.1.5. Phase 4 – Proposal Ranking

C.2. Phase 1- Evaluation of Part One- The Minimum Requirements

C.2.1. The purpose of this phase is to determine whether each proposal is sufficiently responsive to the minimum RFP requirements to permit a complete evaluation.

C.2.2. Proposals must comply with the instructions to bidders contained throughout. Failure to comply with the instructions may deem the proposal non-responsive and subject to rejection without further consideration.

C.2.3. The Department reserves the right to waive minor irregularities.

C.2.4. The minimum requirements for a proposal to be given consideration are:

C.2.4.1. Deadline - Closing Date: The proposal must have been received, before the closing of acceptance of proposals.

C.2.4.2. Delivery Condition - Copies Necessary: The original (clearly marked) and eight (8) exact, legible copies of the proposal must be submitted in properly marked, sealed envelopes or sealed boxes by the deadline.

C.2.4.3. Transmittal Letter: The proposal contains a transmittal letter of no more than four (4) pages that addresses each of the requirements in Section IV A 1.2 through 1.4.

C.2.4.4. Mandatory Conditions: The bidder must accept the RFP Mandatory Terms and Conditions and Procurement and Contractual Agreements. Required Forms: The bidder must provide the necessary signed forms.

C.3. Phase 2- Evaluation of Technical Proposal- Sections Two and Three:

C.3.1. Only those proposals passing the minimum requirements will be considered in Phase 2 – The Evaluation of Sections Two and Three. The State reserves the right to reject any and all proposals.

C.3.2. The Department will evaluate the Bidder's ability to perform all functions within the Scope of Work as outlined in Section V of the RFP.

C.3.3. The quality of the work plan and the project management will be evaluated including the organization, completeness and logic of the proposed plan. The evaluation will consider how innovative and creative the bidder is in responding to the functional and technical requirements outlined in this document.

C.3.4. The Department will evaluate the experience of key members of the team, corporate and individual resources, corporate qualifications and affirmative action achievement (as demonstrated on the Workforce Analysis Form) of the bidder and any Subcontractors.

C.3.5. The Department will determine to what extent the organization and its key personnel have the ability to work effectively with the Department to develop and implement a successful system. The Department will also assess the capability of the organization to take on the additional workload that would be generated by the contract resulting from this RFP and the bidder's financial ability to undertake the contract. The Department will check references.

C.4. Phase 3- Evaluation of Section Five -- Business- Cost (15 double-sided pages)

C.4.1. The Department will evaluate the Bidder's cost and price information, including the financial stability in response to the RFP requirements.

C.4.2. The bids in this proposal are to remain fixed by phase for the term of the contract and represent the total fees for the scope of work required by the RFP.

C.4.3. The Department will evaluate the financial stability of the Bidder through an examination of

C.4.3.1. Audited Financial Statements;

C.4.3.2. Lines of Credit and

C.4.3.3. Debt Ratings: Short-term and long-term debt ratings by at least one nationally recognized rating service, if applicable.

C.4.4. The Department will evaluate the Bidder's response to the:

C.4.4.1. Business Narrative through which the Bidder explains and details the projected costs under the contract resulting from this RFP.

C.4.4.1.1. There must be a separate narrative for each bid option (A1/A2 and B1/B2).

C.4.4.2. Completed Budget Template in Exhibit F for Options A1/A2 and B1/B2 including:

C.4.4.2.1. The PMPM for the administrative services required to meet the requirements of this RFP and corresponding budget responsive to each of the aforementioned scope options; and

C.4.4.2.2. the identification of any additional costs associated with the services specified in this RFP that are not included in the costs quoted above.

C.4.5. The Department will evaluate the Bidder's description of how the Contractor will monitor and respond to increases in enrollment that surpass projected enrollment in terms of deploying or adjusting staffing for specific administrative functions (e.g., Utilization Management, Member Services, Intensive Care Management). This response must specifically address how the additional administrative revenues would be distributed to the administrative functions.

C.4.6. The Business Proposal will be scored for cost and cost reasonableness. Cost reasonableness will be determined by examining the business narrative and the relationship between costs, personnel and the work plan outlined in the proposal.

C.4.7. The Cost comparison will be determined by comparing bid price information.

C.4.8. While cost is a factor in determining the bidder with the right to negotiate a contract with the Department, price alone shall not determine the winning bidder.

C.5. Phase 4- Presentation and Ranking of the Proposals

C.5.1. Upon completion of Phases 1-3, it is possible that persons participating on the Evaluation Committee will interview the finalists.

C.5.2. After the Evaluation Committee has scored the proposals, the points awarded will

be totaled to determine the ranking. Recommendations, along with pertinent supporting materials, will then be conveyed to the Commissioners.