State of Connecticut
Department of Social Services
Medicaid Managed Care – HUSKY A, SCHIP Managed Care – HUSKY B, and Charter Oak Managed Care
For the State of Connecticut

REQUEST FOR PROPOSALS

010308DSS_HUSKY_CO_RFP

SEVENTH Addendum

RELEASE DATE - 032408

The following information amends the contents of the original RFP issued on January 1, 2008.

A. In Section II – OVERVIEW OF THE PROCUREMENT PROCESS (RFP Pages 7 – 16) revisions have been made to the following sections: Section 2 – Procurement Schedule (page 7); Section 3 – Bidders' Questions (page 8); and Section 14 – Response Date and Time(page 12)

2. Procurement Schedule – The Department has revised the Procurement Schedule as follows:

Milestones	Ending Dates
Deadline for Questions pertaining to Addendums 1 – 6: 3:00 PM Local Time	**03/26/08**
Responses to Questions (tentative)	**03/28/08**
Technical Proposals – Responses to Parts One, Two and Three - Due by 3:00 PM Local Time	**04/04/08**
Cost Proposal – Response to Part Four - Due by 3:00 PM Local Time	**04/11/08**
Successful Bidder Announced	TBD
Contract Negotiations Begin	TBD
Contract Begins (tentative)	07/01/08

3. Bidders' Questions – The Department has revised the submission date for Bidders' Questions as follows:

The Department will accept written questions and requests for clarification pertaining to Addendums 1 through 6 for this procurement if submitted to and received by the Issuing Office by **3:00 pm on March 26, 2008.** 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 respond to only those questions that meet the deadline and criteria listed above. 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 Charter Oak page on the Department's website at www.ct.gov/dss/charteroak and the State Procurement/Contracting Portal www.das.state.ct.us/Purchase/Portal/Portal_home.asp. The tentative posting date for the addendum is March 28, 2008. In addition to the posting of the questions and Department responses, the addendum will include the Department's anticipated date for the announcement of the successful bidder and the schedule of contract negotiations. It is solely the Bidder's responsibility to access the Charter Oak page on 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.**

14. Response Date and Time

The Issuing Office must receive the Bidders' response to the proposal requirements for the Technical Proposal (Part One: Transmittal Communications, Forms and Acceptances; Part Two: Organization, Key Personnel and Experience; and Part Three: Scope of Work) no later than **3:00 p.m. local time on Friday April 4, 2008.**

The Issuing Office must receive the Bidders' response to the proposal requirements for the Cost Proposal (Part Four: Price and Financial Information) no later than **3:00 p.m. local time on Friday April 11, 2008.**

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.

B. On pages 4 through 9 of this addendum the Department is providing responses to certain questions raised in accordance with the provisions of the RFP.

This **SEVENTH Addendum to 010308DSS_HUSKY_CO_RFP** is being issued by the Issuing Office on the 24th day of March, 2008.

This Addendum must be signed and returned with your submission.

_____	_____
Authorized Signer	Company Name

Approved _____
Kathleen M. Brennan
State of Connecticut
Department of Social Services
(Original Signature on Document in Procurement File)

	Source	Paragraph Cite (s)	Page Number	Question	Response
1	RFP	II.7	9	In order for bidders to prepare a proposal that is organized in a concise and logical manner for the reviewers' ease of evaluation, it would be helpful if the State would elaborate on the scoring process used to select a vendor (e.g., the number of points assigned to each section of the RFP that will be scored).	70% of the total points available will be assigned to the evaluation of the Organizational Capacity, Structure and Scope of Work (Phase Two). The remaining 30% will be assigned to the evaluation of the Business (Cost) Proposal (Phase Three). 70% of the total points available for Phase Three will be weighted towards the Bidders' Business (Cost) submission. The remaining 30% will be weighted towards the best and final offer.
2	RFP	IV - Part Two - 4B	26	Our company has contracts with other state agencies who have indicated that, as a matter of policy, they do not provide a ranking among their contracted providers. May we ask those state agencies to provide a summary of our performance with relevant measures, without the explicit reference to ranking each area?	Yes.
3	RFP	IV - Part Three - 3.09a and 3.09b	46	Please clarify how it will calculate the ratios it refers to in sections 3.09a and 3.09b regarding network adequacy? Please provide the equation it will use or sample calculations?	The ratio of members to physicians was determined based on the Fee-For-Service data prior to the implementationof managed care. The ratios are applied to each county for each type of provider category cited (Adult, Children and Women) as explained in 3.09b and compared to the number of HUSKY members in that county.
4	RFP	IV - Part Three - 3.09a and 3.09b	46	How is this methodology applied to the State's Medicaid fee for service population?	This question does not pertain to a requirement of the RFP or the resultant contract.
5	RFP	IV - Part Three - 3.09a and 3.09b	46	Please provide the non-hospital reimbursement schedules and the hospital-specific payment rates in excel format.	This sixth addendum includes the Department's updated fee schedules and a narrative summary of the same.

6	RFP	IV - Part Three - 3.34 b 3	91	This section implies for a report due 12/31/08 including utilization data for the quarter ending 9/30/08, the State will have provided specifications for that report on or before 10/1/08. How will you provide the MCO assurance that the data elements of such reports requested are already required to be captured in the MCO's reporting system? To ensure that MCOs are capturing and reporting all data elements needed by the State, would the State consider providing the specifications for reports 90 days prior to the data capture period?	Specifications for required reports are posted to the Bidders' Library. If additional reports are required the resultant Contractor(s) would have ninety (90) days to implement.
7	RFP	IV - Part Three - 3.39	101	For Members who lose eligibility and then regain it within 60 days, we understand that they will be re-enrolled retroactively so that there is no break in coverage. For a claim incurred and submitted to the MCO after the Member lost eligibility but before the Member regained eligibility, the MCO would (appropriately) deny the claim initially. Then, when the DEPARTMENT notifies the MCO that the Member has regained eligibility and that there is no break in coverage, the provider may resubmit the claim and the MCO would pay it. Please confirm that the MCO would not owe the provider an interest payment in this situation, provided that the MCO pays the claim within 45 days of receipt of resubmission.	Section 3.39 refers to timely processing of a clean claim. If the claim processes within the forty-five (45) days of receipt and the client is not eligible, the claim should be denied and should appear in the Denied Claims report. If the Contractor receives a subsequent retro-enrollment transaction for that previously ineligible date of service, the contractor may reprocess the originally denied claims due to "member not eligible on date of service" as a service to their in-network providers or reprocess the claim upon resubmitall from the provider. Under the former scenario the count of the 45 days for timely filing would begin with notification of the re-enrollment. Under the latter scenario, the 45 days would start with the resubmittal date.

8	RFP	IV - Part Three - 5.16 a 1 & 2	138	Please describe how the co-payment and co-insurance information for services provided by the CT BHP ASO, the dental ASO and pharmacy services managed by the DEPARTMENT will be transmitted to the MCO.	There are no co-pays for HUSKY B CT BHP services. Pharmacy co-pay data will either be included in the pharmacy file the Department plans to make available to contractors for Quality Assurance and Case Management purposes or in a separate file combined with Dental co-payment data for HUSKY B and Behavioral Health co-payment data for Charter Oak.
9	RFP	V	193	What are the available points for Phases Two and Three?	Phase Two - Evaluation of the Organizational Capacity, Structure and Scope of work - 70%. Evaluation of the Business Cost Proposal - 30%.
10	RFP	General Question	N/A	When there is not a "bidder shall" requirement in a contract section, do we need to make a general statement of acceptance for each section?	"Bidder shall" sections require a response. If the bidder is asked to provide specific information, the bidder must respond with the requested information. If specific information is not asked for the bidder should make a general statement of acceptance for that specific section.
11	Addendum 3, Appendix A	Item 15	19-20	This amendment clarifies the MCOs responsibilities for payment of J codes. The amendment also includes in a. Covered Services, Subsection i a reference to the MCO's formulary. The RFP and specific questions related to pharmacy reference the Department's Preferred Drug List. Please verify that it is the Department's intent that MCOs use the Department's PDL as stated in Section 3.16 page 56 of the RFP and not the MCO's own formulary?	MCO providers are required to utilize the Department's PDL when prescribing medications to be filled at retail pharmacies. The Department's PDL does not apply to injectibles or J-code drugs administered at a provider's office, hospital or facility.
12	Addendum 3, Attachment F	3	N/A	Attachment F includes a third page labeled "Consulting Agreement Affidavit" which is not addressed in the RFP. Are Bidders required to complete this form in addition to the gift and campaign affidavits?	**YES**

13	Addendum 4, Procurement Schedule	Item 2		DSS has moved the due date of the technical proposal to 3/28.2008 and the due date of the cost proposal to 4/11/2008. What amount of time does DSS estimate it will take for review of the proposals, contract negotiation and contract execution? And, given that estimate, what amount of time does DSS estimate it will take to review and approve member marketing materials that may be used by the contracted providers during open enrollment, scheduled to begin May 1, 2008? Will DSS review all member education materials at the same time as it is reviewing the marketing materials so that the MCOs may have them available for distribution to new members upon enrollment?	DSS will be working to review all materials in order to have them available for distribution tonew members upon enrollment.
14	Bidder's Conference	N/A	N/A	Mercer stated that the rate range projections would be based on a combination of encounter data and financial data. Will the same financial data be made available to prospective bidders?	As stated in the Fifth Addendum to the RFP, the Department is preparing a data book for the Bidders' use in developing its Business (Cost) Proposal. The data book will be posted as an addendum to this RFP, will be posted to the Bidders' Library and will provide a summary of the HUSKY financial and encounter data reporting. The data book is expected to be posted the week of March 31, 2008.
15	Bidder's Conference	N/A	N/A	Reference was made to the future release demographic and FPL data for Charter Oak eligibles. Is this still the intent and what is the estimated time of delivery for the data?	Information on estimated enrollment by FPL levels was provided in the Prospectus (released 10/07, page 49). Additional estimated enrollment by age/gender should be available by 3/14/08.
16	Bidder's Conference	N/A	N/A	The initial design of Charter Oak has one rate regardless of age/gender. Please confirm that age/gender rates will be allowed for Charter Oak.	Age/gender rates will not be allowed in the Base Plan design as outlined in the RFP. The Alternative Plan design proposed by the bidder may suggest rates by age/gender.
17	Bidder's Conference	N/A	N/A	Do the "actuarially sound" rate ranges for Charter Oak include a factor for the higher-than-average risk members this plan will attract?	Yes, acuity and adverse selection adjustments will be included in the rate ranges.
18	Bidder's Conference	N/A	N/A	Please confirm that the State considers a 2% target return on a three-year rolling basis appropriate.	The information, if available, will be released during contract negotiations with the selected contractor(s).
19	Bidder's Conference	N/A	N/A	Please confirm that the State will release a target administrative percentage in a future addendum.	The information, if available, will be released during contract negotiations with the selected contractor(s).

20	Bidder's Conference	N/A	N/A	Please confirm that premium billing and collection will be performed by the State or another Vendor and will not be an MCO responsibility for HUSKY B and Charter Oak members. If so, please confirm that Bidders do not have to respond to the **bidders shall** in Section 5 of the Scope of Work (5.10 and 5.18) related to premium billing. How will the MCO receive premium billing and collection information from the State for purposes of accumulating premiums for maximum cost-sharing and determining whether overpayments have occurred?	The premium billing and collection will be performed by the Department or its agent and will not be the responsibility of the MCO for HUSKY B and Charter Oak. The Fifth Addendum to the RFP deleted the bidder's obligation to respond to Sections 5.03, 5.04, 5.05, 5.06, 5.08, 5.09 and 5.10 does not have to respond to Sections 5.10. The bidder is also NOT required to respond to Section 5.18, related to premium tracking. The Department or its agent will track premium billing and make this information available to the MCO on the same file as pharmacy, dental and behavioral health co-payment information. See Q & A number 8.
21	RFP	4.b, IV.3.10 Definitions , and 8.0-Standard Terms and Conditions	26, 38, 180	Given the State's definitions of "subcontractors", please provide clarification on the type of service providers that are considered to be a subcontractor for purposes of responding to Part 2 of this RFP. For example, do Bidder's need to identify and provide references and background information for subcontractors who provide interpretive services or a segment of the credentialing process (e.g. third party verification) or the claims process (e.g. document management)?	For purposes of responding to Part 2 of this RFP a Subcontractor shall be any service provider who is managing or providing a medical service required under the terms of the contract.
22	RFP	5.12	135	For the Charter Oak CRCS, should we assume that just MCO claims count toward the deductible (including claims from another MCO if the member was enrolled in that MCO during the same eligibility period)? Or, should we assume that CT ASO and pharmacy claims also count toward the deductible. Both behavioral health and pharmacy have co-payments and coinsurance that should not apply until the deductible is met."	For Charter Oak, only coinsurance counts towards the deductible or out-of-pocket maximums. Also, Charter Oak members will be locked-in for 12 months into their selected MCO. Pharmacy and BH (with the exception of BH inpatient) have copays, which will not need to be counted towards the deductible or out-of-pocket maximums. For BH inpatient, the co-insurance will need to be included in the deductible and/or out-of-pocket maximums.

23	RFP, Addendum 3, Attachment B, and Attachment C	N/A	N/A	Where should Bidders address Affirmative Action Plan requirements? -Part 1- Section 1.6 narrative -In Attachment C as an appendix, or -On the second page of Attachment B	As an appendix to Attachment C.
24	Appendix A	1		Appendix A states: "The Behavioral Health Partnership ("BHP") is responsible for providing services for behavioral health conditions. The Department is responsible for Dental and Pharmacy services." Should this be interpreted as meaning that all costs associated with these services (BH, Dental & pharmacy) be excluded from the capitation rate? If not, then which specific services will remain the financial responsibility of the MCO?	This RFP defines when an MCO may be responsible for CT BHP, Dental and Pharmacy services. Bidders are responsible for factoring the costs for which it will be responsible in its proposed capitation rate.
25	Appendix A	1		If pharmacy services are not included in the capitation payment, the following clarification is requested. Are claims associated with all pharmaceutical products, including both legend drugs and over-the-counter drugs, I.e., any pharmaceutical product having an NDC number, indeed not the responsibility of the MCO, regardless of whether submitted as a pharmacy claim or medical claim?	The responsible party for paying pharmacy claims will be determined by the point of service. The MCO will be responsible for medical claims including those claims for pharmacy products administered by a doctor or other qualified provider in his or her office. These drugs may include specialty drugs that have a limited shelf life and require coordination between the supplier and the doctor and are not typically available through a pharmacy. This exception does not apply to immunizations that are avaiable free from the CT Department of Public Health. The Department will be responsible for those services (pharmacy products) delivered by a pharmacist.