

**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

SECOND Addendum

RELEASE DATE – 022008

Cost Proposal Requirements and Bidders' Conference

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

1. At the time of the release of 010308DSS_HUSKY_CO_RFP, the Department had not completed its review of certain components within the requirements of the RFP. These included specific requirements for the Cost Proposal. With the release of this second addendum the Department has released instructions for the completion of the cost proposal (pdf file) and cost proposal templates (excel spreadsheets). These documents are reproduced in this addendum in a pdf format but each organization that has provided a Letter of Intent to bid will also receive the excel spreadsheets via e-mail.

2. SECTION II – OVERVIEW OF THE PROCUREMENT PROCESS – SUBSECTION 5. The Bidders' Conference for potential bidders to ask clarifying questions pertaining to the requirements of the RFP shall be held on **FRIDAY, FEBRUARY 22, 2008 from 10:00 am – 12:00 pm** in Mezzanine Conference Room 2 A & B at the State of Connecticut Department of Social Services Central Office located at 25 Sigourney Street, Hartford, CT. **NOTE WELL:** Responses to those questions raised at the Bidders' Conference will not be deemed "OFFICIAL" until they are posted as an amendment to the RFP in a subsequent addendum.

To ensure the availability of adequate space for all interested parties, organizations have been limited to NO MORE than two (2) attendees. For building access and security purposes interested parties were required to submit to the Issuing Office a list of planned attendees by 3:00 PM ON WEDNESDAY, FEBRUARY 20, 2008. **PLEASE NOTE:** Identification will be checked and

access will be granted only to those individuals on the security list provided by the Department to building security.

While the primary purpose of the Bidders' Conference is to allow Bidders' the opportunity to ask clarifying questions pertaining to the requirements of the RFP, the Department will be providing an overview of the Cost Proposal requirements issued through this addendum. As previously stated while the Department may provide tentative responses to questions raised at the Bidders' Conference, the Department's responses will not be deemed OFFICIAL until they are posted as a subsequent addendum to this RFP.

This SECOND Addendum to 010308DSS_HUSKY_CO_RFP is being issued by the Issuing Office on the 20th day of February, 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)

**STATE OF CONNECTICUT HUSKY PROGRAM
AND CHARTER OAK PROGRAM**

July 1, 2008 – June 30, 2009

**INSTRUCTIONS FOR COMPLETING THE COST
PROPOSAL AND CAPITATION RATE CALCULATION
SHEET (CRCS)**

Table of Contents

A. GENERAL	1
B. REQUIREMENTS FOR SUBMISSION OF ACCOMPANYING NARRATIVE	2
C. COMPLETING THE COST PROPOSAL	3
D. INSTRUCTIONS FOR COMPLETING THE CRCS FORMS	6
E. INSTRUCTIONS FOR COMPLETING HUSKY SCHEDULE 2	13
F. INSTRUCTIONS FOR COMPLETING HUSKY SCHEDULE 3	13
G. RATE NEGOTIATION PROCESS	13
ATTACHMENT 1 – COST PROPOSAL EXCEL FILE	15
ATTACHMENT 2 – EXAMPLE OF DETAILED NARRATIVE	33
ATTACHMENT 3 – CATEGORY OF SERVICE DESCRIPTIONS	40
ATTACHMENT 4 – MATERNITY SUPPLEMENTAL INFORMATION DESCRIPTION	48
ATTACHMENT 5 – NEWBORN SUPPLEMENTAL INFORMATION DESCRIPTION	49

A. General

This document includes instructions for preparing the capitation cost bids for the State of Connecticut (State) HUSKY Program and Charter Oak Program for the contract period July 1, 2008 through June 30, 2009. The Contractor is advised to review this entire document carefully and follow all instructions.

The information requested in this document is required to support the reasonableness of the capitation cost bids and is for internal Department of Social Services (Department or DSS) use. This information serves as a useful tool for both the Department and Contractor in terms of understanding the Contractor's rationale for its capitation cost bid, facilitating evaluations and negotiations, and serving as a planning and monitoring tool. Any information provided in response to the bid is subject to the Section 1-210 of the Connecticut General Statutes "Access to public records. Exempt records." Bidders in its response to this Request for Proposal (RFP) may declare specific components of their proposal to be proprietary. However, such declarations must comply with the Freedom of Information Act (FOIA) and with Section 1-210 (b) of the Connecticut General Statutes. Bidders making proprietary declarations must clearly identify those sentences or subsections with rationale that complies with FOIA to claim proprietary exemption. The State will not accept blanket declarations. The bidder must explain the rationale for the proprietary claim in terms of the prospective harm to the competitive position of the bidder that would result if the identified material were to be released. The bidder must also state the legal argument for exempting the materials pursuant to the statute cited above. The Proprietary Declaration must be located immediately following the Table of Contents. While the bidder may claim proprietary exemptions, any decision to release information subject to a FOIA request shall remain with the State.

The Department will accept bids from full risk Managed Care Organizations (MCOs). The term "Contractor" throughout this document is intended to refer to the MCO preparing the bid.

Capitation is designed to provide the Contractor with a prospectively determined monthly payment so it may provide services that meet program standards. The Contractor, in these bids, **must** demonstrate that its proposed capitation rates were developed in an actuarially sound manner. The basis of all financial projections **must** be linked to the capitation cost bids. The Contractor may require assistance from an actuary to develop some of the fundamental assumptions for meeting the criteria defined below.

To assist the Contractor with the preparation of its capitation cost bids, the Department will make available, upon request, a data library with relevant historical, financial and eligibility information program changes, and other relevant information necessary to prepare the bid. The data library should not be used as the only source of information in making decisions concerning the capitation cost bids. The Contractor is solely responsible for research, preparation, and documentation of its capitation cost bids.

The capitation cost bids **must** consist of a CRCS for each rating group for each program (HUSKY A, HUSKY B, Charter Oak) for which the Contractor is submitting a bid along with the accompanying schedules. The program Rating Groups, Categories of Services and instructions for the Cost Proposal are described below. The Cost Proposal forms can be found in Attachment 1.

The following **must** be submitted to the Department:

Eight hard copies of the Cost Proposal signed by the responsible individual **and two electronic copies**, using the Excel file provided by the Department in the rate package (Attachment 1).

In the event of a discrepancy between Cost Proposal information submitted electronically and the hard copy version, the hard copy will be utilized for evaluation of the capitation cost bids.

B. Requirements for Submission of Accompanying Narrative

Separate detailed narrative should be provided for both HUSKY and Charter Oak.

B.1. Requirements for Submission of Accompanying HUSKY Narrative

A detailed Narrative must be provided that explains the Contractor's rate-setting methodology. The Contractor should describe in detail the data sources and actuarial assumptions used in developing the July 1, 2008 through June 30, 2009 rates. Attachment 2A provides an example of the specific information to be included in the Narrative. The following should be provided:

- a) The data sources used
- b) The programmatic changes incorporated and their values
- c) Managed care trend rates applied
- d) Other utilization assumptions including impact of managed care efforts on the utilization rates
- e) Other unit cost assumptions, including identification of provider fee schedule arrangements (including satisfying Section 3.47.g of the RFP), capitation arrangements, reinsurance, risk sharing, withholds or incentive payment arrangements
- f) Enrollment projections and assumptions
- g) Reinsurance premiums and recovery estimates
- h) Pro forma income statements
- i) Administrative contracts and related party charges
- j) Start-up costs
- k) Underwriting gain and risk/contingency margin justification
- l) Any other assumptions the Contractor has included in its projections

B.2. Requirements for Submission of Accompanying Charter Oak Narrative

A detailed Narrative must be provided that explains the Contractor's Charter Oak rate-setting methodology. The Contractor should describe in detail the data sources and actuarial assumptions used in developing the July 1, 2008 through June 30, 2009 rates. Attachment 2B provides an example of the specific information to be included in the Narrative. The following should be provided:

- a) The data sources used
- b) The programmatic changes incorporated and their values
- c) Managed care trend rates applied
- d) Other utilization assumptions including impact of managed care efforts on the utilization rates
- e) Other unit cost assumptions, including identification of provider fee schedule arrangements, capitation arrangements, risk sharing, withholds or incentive payment arrangements
- f) Enrollment projections and assumptions
- g) Administrative contracts and related party charges
- h) Start-up costs
- i) Underwriting gain and risk/contingency margin justification
- j) Source of age/sex factors
- k) Source of family factors
- l) Source of Federal Poverty Level (FPL) factors
- m) Any other assumptions the Contractor has included in its projections

C. Completing the Cost Proposal

NOTE: The Department will provide an electronic copy of the cost proposal in the rate package that must be used by the Contractor. This file will be in Excel format. Please contact Kathleen Brennan by e-mail at kathleen.brennan@ct.gov or by phone at 860 424 5693 if you encounter problems accessing or utilizing this file. As this workbook has been provided solely to facilitate completing the Cost Proposal, it is the Contractor's responsibility to review all components of the Cost Proposal prior to submission for reasonableness and validity of the amounts resulting from the calculations performed by the formulas provided.

C.1. Completing the HUSKY Cost Proposal

The HUSKY Cost Proposal consists of multiple tabs within the Excel workbook.

1. **Schedule 1:** Includes plan information, contact information and a certification to be signed by the Chief Executive Officer of the Contractor and the actuary, if used, to prepare the bid.

2. CRCS forms for each of seven rating groups in HUSKY A and three rating groups in HUSKY B. Each rating group is Statewide. The Contractor is required to develop and submit separate capitation cost bids for each statewide rating group.

The rating groups for HUSKY A are as follows:

- a) Rating Group 1: TANF Less than One Year Old
- b) Rating Group 2: TANF Children Age 1–14 M&F
- c) Rating Group 3: SSI Children Age 0–20 M&F
- d) Rating Group 4: DCF Children Age 0–20 M&F
- e) Rating Group 5: TANF Females Age 15–40
- f) Rating Group 6: TANF Males Ages 15–40
- g) Rating Group 7: TANF Ages 40+ M&F

Supplemental information for HUSKY A is as follows:

- h) Supplemental Group 1: Maternity Supplemental
- i) Supplemental Group 2: Newborn Supplemental

The rating groups for HUSKY B are as follows:

- a) Rating Group 1: HUSKY B Band 1 (185% – 235% FPL) All Ages
- b) Rating Group 2: HUSKY B Band 2 (235% – 300% FPL) All Ages
- c) Rating Group 3: HUSKY B Band 3 (Over 300% FPL) All Ages

Note that the costs for the maternity and newborn supplemental payments should be included in the appropriate age/sex HUSKY A rating group. The Department may utilize these supplemental costs for maternity and newborns for the development of a maternity and newborn supplemental payment.

3. **Schedule 2:** Includes administrative cost detail by expense classification and department used to support the administrative costs included in the CRCS forms. The total administrative cost from Schedule 2 must be consistent with the administrative per member per month (PMPM) amounts entered on the CRCS forms when converted to a total dollar amount across all rating groups combined.
4. **Schedule 3:** Requests supplemental information on the capitated risk arrangements and how they are reported in the CRCS forms.

The Contractor should begin development of its capitation cost bids by estimating utilization and unit costs for each category of service (COS) within the rating groups described above. Instructions follow regarding the method of calculating the various utilization frequencies and unit costs.

The unit cost estimates should be based on the anticipated reimbursement arrangements negotiated with the subcontractor(s) or provider(s) in the MCO's network, including hospitals, outpatient clinics, physicians, etc. Adjustments should be made to account for the full effect of expected inflation within the contract period. The estimates should reflect expected costs, before the application of any anticipated reinsurance recoveries. Any reinsurance recoveries for claims incurred in the rating period should be included on line 14 and entered as a negative value. Reinsurance premiums are reflected on line 16, if applicable.

The Contractor should take full advantage of its position as a purchaser of health care for HUSKY recipients on behalf of the Department to negotiate as favorable a rate as possible with its providers. However, Section 3.47.g of the RFP requires that "Reimbursement by the MCO to all providers shall be at no less than the DEPARTMENT'S Medicaid fee schedule." The current Medicaid fee schedules are available in the bidders' library that can be accessed at www.ct.gov/dss/charteroak and the State's Procurement/Contracting portal at www.das.state.ct.us.

The Contractor should prepare capitation cost bids for the contract period from July 1, 2008 through June 30, 2009.

C.2. Completing the Charter Oak Cost Proposal

The Cost Proposal for the Charter Oak program is similar to that used for the HUSKY program, consisting of multiple tabs within the Excel workbook.

1. **Schedule 1:** Includes plan information, contact information and a certification to be signed by the Chief Executive Officer of the Contractor and the actuary, if used, to prepare the bid and is applicable to the Charter Oak program as well as the HUSKY program.
2. Bid forms for the Charter Oak program. The Contractor is required to develop and submit a single community-rated capitation cost bid for Charter Oak program using the Base Plan Design in the RFP. The intent of the single community-rated bid is to achieve a Target Premium of \$250 for individuals with incomes at 300% FPL and above, regardless of age, sex, or geography.

The Contractor should begin development of its capitation cost bids by developing an average PMPM expenditure estimate for individuals with incomes 300% FPL and above upon which to base its capitation estimate. For Charter Oak, DSS has provided 5 categories that the Contractor must provide adjustments for to the average PMPM expenditure estimate. DSS has provided 3 additional columns for any other adjustments the Contractor deems necessary to make the average PMPM expenditure estimate appropriate for individuals with incomes 300% and above. In a later step, DSS provides the Contractor with the ability to vary the rate by FPL by applying a factor to adjust for the varying deductible and out-of-pocket maximums applicable by FPL.

The unit cost estimates should be based on the anticipated reimbursement arrangements negotiated with the subcontractor(s) or provider(s) in the MCO's network, including hospitals, outpatient clinics, physicians, etc. Adjustments should be made to account for the full effect of expected inflation within the contract period. The estimates should reflect expected costs, before the application of any anticipated reinsurance recoveries.

The Contractor should take full advantage of its position as a purchaser of health care for HUSKY recipients on behalf of the Department to negotiate as favorable a rate as possible with its providers for Charter Oak. However, Section 3.47.g of the RFP requires that "Reimbursement by the MCO to all providers shall be at no less than the DEPARTMENT'S Medicaid fee schedule." The current Medicaid fee schedules are available in the bidders' library that can be accessed at www.ct.gov/dss/charteroak and the State's Procurement/Contracting portal at www.das.state.ct.us.

The Contractor should prepare capitation cost bids for the contract period from July 1, 2008 through June 30, 2009.

D. Instructions for Completing the CRCS Forms

D.1. Instructions for Completing the HUSKY CRCS Forms

The Contractor is required to input all items highlighted in blue on the CRCS forms.

1. Enter the MCO's estimated member months (MMs). The rating group for which the CRCS is being prepared and the rating period are already identified by the Department.

For the newborn supplemental information, enter the estimated number of births, including stillborns. Provide the percentage assumption of stillborns and multiples included in the projections.

For the maternity supplemental information, enter the estimated number of deliveries, including stillborns. Provide the percentage assumption of C-section deliveries compared to the total number of deliveries.

2. Categories of Service – Column one contains the eleven categories of service, which include the following:
 - a) Physical Health – Inpatient Hospital
 - b) Physical Health – Non-Emergent Outpatient Hospital
 - c) Outpatient Hospital – Emergency Room
 - d) Physician – Primary Care
 - e) Physician – Specialty Care
 - f) Emergency Transportation
 - g) Non-Emergency Transportation
 - h) Lab/Radiology
 - i) Durable Medical Equipment
 - j) Vision
 - k) Other

For a description of the categories of service, please refer to Attachment 3.

3. Unit description – the unit description is provided in column for each category of service listed above. Contractors are expected to use this unit definition when completing the utilization and unit cost information in column 4 and column 5. Units are defined either as days, visits, trips (one-way), procedures, or services.
4. Copay amounts – for certain rating categories and services, Contractor's are expected to collect a copayment from the member. These copayments are listed in column 3. If there is no copayment, the cell is blank.
5. Utilization per 1,000 (lines 1 through 10 and 11a-e) – enter the annual utilization per 1,000 (calculated by multiplying utilization by 12,000 and dividing by the MMs) for each category of service based on the appropriate unit description. For the newborn and maternity supplemental information, note that the utilization is entered per births or per delivery respectively.
6. Unit Cost (lines 1 through 10 and 11a-e) – enter a cost per unit (expressed in dollars and cents) for each category of service, based on the same unit description used for the utilization per 1,000. Unit cost should be expressed net of any copay amounts where applicable.
7. The PMPM is calculated by multiplying the utilization per 1,000 by unit cost and dividing the result by 12,000 (this calculation will be performed automatically by the formula entered in the electronic file provided).
8. Total Medical Expenses (line 12) is calculated by adding PMPM costs for each service (this calculation will be performed automatically by the formula entered in the electronic file provided).

9. Third Party Liability (line 13) should be entered as PMPM amounts. The PMPM amounts should be entered as a negative value since it is expected to reduce the capitation needed. This represents total recoveries related to incurred health care services eligible where Medicaid is not the prime insurance coverage source. The MCO should include all third party recoveries expected to be collected for claims incurred during the contract period.
10. Reinsurance Recoveries (line 14) should be entered as PMPM amounts. The PMPM amounts should be entered as a negative value since it is expected to reduce the capitation needed. This represents total recoveries related to incurred health care services eligible for reinsurance. The MCOs should include all reinsurance recoveries expected to be collected for claims incurred during the contract period.
11. Net Medical Expenses (line 15) is calculated by adding the PMPM costs from Total Medical Expenses (line 12), Third Party Liability (line 13) and Reinsurance Recoveries (line 14) (this calculation will be performed automatically by the formula entered in the electronic file provided).
12. Reinsurance Premium (line 16) includes premium expenditures related to the cost of catastrophic claims insurance. This should be entered as a PMPM amount.
13. Administration (line 17) should be entered as a percentage of the total capitation rate (line 20). The PMPM costs will be automatically calculated based on this percentage. These represent the allocation of the expenditures listed in Schedule 2 and include expenditures associated with the overall management and operation of the MCO. The total administrative cost from Schedule 2 must be consistent with the administrative PMPM amounts entered on the CRCS forms when converted to a total dollar amount across all rating groups combined.
14. Underwriting Gain (line 18) should be entered as a percentage of the total capitation rate (line 20). The PMPM costs will be automatically calculated based on this percentage. This represents the amount of profit included by the Contractor in the cost proposal.
15. Risk/Contingency Margin (line 19) should be entered as a percentage of the total capitation rate (line 20). The PMPM costs will be automatically calculated based on this percentage.
16. Total Capitation Rate (line 20) is calculated by adding the PMPM costs of the Net Medical Expenses (line 15), Reinsurance Premiums (line 16), Administration (line 17), Underwriting Gain (line 18) and Risk/Contingency (line 19).
17. Medical Loss Ratio (line 21) is calculated by taking the ratio of the Net Medical Expenses (line 15) PMPM plus the Reinsurance Premium (line 16) PMPM over the Total Capitation Rate PMPM (line 20). While the Department currently does not have specific Medical Loss Ratio requirements included as part of this RFP, the

Department reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

18. Preparer **must** sign, date, and enter the name of the organization preparing the CRCS, the name of the actuary used (if any), and the actuary's firm. This is required on Schedule 1.
19. Repeat steps 1 through 17 for each rating group for each program. Note: For the maternity supplemental information, steps 1 through 17 should be performed separately for vaginal delivery types and C-section delivery types. The results of each delivery type are then combined based on the assumed percentage of each delivery type expected by the Contractor.

D.2. Instructions for Completing the Charter Oak CRCS Forms

The Contractor is required to input all items highlighted in blue on the CRCS forms.

1. Confirm Contractor's organization at the top of each bid form.
2. Enter the Contractor's estimated member months (MMs). The rating group for which the CRCS is being prepared and the rating period are already identified by the Department.
3. Provide base data used for the calculations, summarized using the Categories of Service in Column B and noted below:
 - a) Physical Health – Inpatient Hospital
 - b) Physical Health – Non-Emergent Outpatient Hospital
 - c) Outpatient Hospital – Emergency Room
 - d) Physician – Primary Care
 - e) Physician – Specialty Care
 - f) Emergency Transportation
 - g) Non-Emergency Transportation (not covered in Charter Oak)
 - h) Lab/Radiology
 - i) Durable Medical Equipment
 - j) Vision
 - k) Other
 - l) Pharmacy (Carved-out, MCO not at-risk)
 - m) Specialty Behavioral Health (Carved-out, MCO not at risk)

For Charter Oak, although the MCO is not at risk for Pharmacy and Specialty Behavioral Health services, these expenditures are included within the Target Premium of \$250. Please include the expected costs for these services at the bottom of the COS listing.

These are the same Categories of Service used to develop the HUSKY Data Book (please also refer to Attachment 3 for more details on how HUSKY claims were summarized). This information will be useful to develop the Charter Oak bid since experience for this population is not yet known.

4. Trend – Supply the trend amount in column D to project the base data used to the SFY09 time period.
5. Copay amounts (Column E) – for certain services, Contractor's are expected to collect a copayment from the member. Supply adjustments for the impact of the copays on all applicable service rows.
6. Deductible (Column F) – All of the participants in Charter Oak must meet a deductible. In this section, please include the value of the full deductible for individuals with income at 300% FPL and above.
7. Out of Pocket Maximum (Column G) – Include any adjustment necessary for the out of pocket maximum for individuals with income at 300% FPL and above.
8. Plan Design (Column H) – Charter Oak's plan design differs from that of the HUSKY program. Please include in this column the value of the differences in covered services between the base data used and the Charter Oak program.
9. Additional Adjustments – Columns I, J, and K are provided to allow the MCO to include additional adjustments to the base data to make it appropriate for the Charter Oak Program. Additional may include, but are not limited to, program changes, additional managed care/education impacts, acuity, pent-up demand, demographic mix, and adverse selection.
10. Total Medical Expenses (line 12) is calculated by adding PMPM costs for each service (this calculation will be performed automatically by the formula entered in the electronic file provided).
11. Unit description – the unit description is provided in column for each category of service listed above. Contractors are expected to use this unit definition when completing the utilization and unit cost information in column N and column O. Units are defined either as days, visits, trips (one-way), procedures, or services.
12. Utilization per 1,000 (lines 1 through 10, 11a-c, Pharmacy, and Specialty Behavioral Health) – enter the annual utilization per 1,000 for SFY09 for each category of service based on the appropriate unit description.
13. Unit Cost (lines 1 through 10 and 11a-c, Pharmacy, and Specialty Behavioral Health) – enter a cost per unit (expressed in dollars and cents) for each category of service, based on the same unit description used for the utilization per 1,000. Unit cost should be expressed net of any copay amounts where applicable.

14. Total Medical Expenses (Column P) is calculated by multiplying the utilization per 1,000 figures in Column N by the unit cost figures in Column O and dividing by 12,000. Column Q is a check to ensure that the PMPM figures calculated in Column P match the PMPM figures calculated in Column L.
15. Third Party Liability (line 13) should be entered as PMPM amounts. The PMPM amounts should be entered as a negative value since it is expected to reduce the capitation needed. This represents total recoveries related to incurred health care services eligible where Charter Oak is not the prime insurance coverage source. The MCO should include all third party recoveries expected to be collected for claims incurred during the contract period.
16. Reinsurance Recoveries (line 14) – For Charter Oak, please bid gross costs. Exclude any recoveries from privately purchased reinsurance policies.
17. Net Medical Expenses (line 15) is calculated by adding the PMPM costs from Total Medical Expenses (line 12), Third Party Liability (line 13) and Reinsurance Recoveries (line 14) (this calculation will be performed automatically by the formula entered in the electronic file provided).
18. Reinsurance Premium (line 16) – For Charter Oak, please bid gross costs. Exclude any private premium expenditures related to the cost of catastrophic claims insurance.
19. Administration (line 17) should be entered as a percentage of the total capitation rate (line 20). The PMPM costs will be automatically calculated based on this percentage. These represent the allocation of the expenditures listed in Schedule 2 and include expenditures associated with the overall management and operation of the MCO. The total administrative cost from Schedule 2 must be consistent with the administrative PMPM amounts entered on the CRCS forms when converted to a total dollar amount across all rating groups combined.
20. Underwriting Gain (line 18) should be entered as a percentage of the total capitation rate (line 20). The PMPM costs will be automatically calculated based on this percentage. This represents the amount of profit included by the Contractor in the cost proposal.
21. Risk/Contingency Margin (line 19) should be entered as a percentage of the total capitation rate (line 20). The PMPM costs will be automatically calculated based on this percentage.
22. Total Capitation Rate (line 20) is calculated by adding the PMPM costs of the Net Medical Expenses (line 15), Reinsurance Premiums (line 16), Administration (line 17), Underwriting Gain (line 18) and Risk/Contingency (line 19).
23. Medical Loss Ratio (line 21) is calculated by taking the ratio of the Net Medical Expenses (line 15) PMPM plus the Reinsurance Premium (line 16) PMPM over the

Total Capitation Rate PMPM (line 20). While the Department currently does not have specific Medical Loss Ratio requirements included as part of this RFP, the Department reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

24. Implied Age/Sex Factors (Section E) – please provide age/sex factors to be applied to the statewide composite bid. These will be used to calculate the implied age/sex rates in Section F. As Charter Oak is intended to be a community-rated product, these age/sex rates are used only to determine the overall composite using the Contractor’s projected enrollment mix by age/sex.
25. Projected Enrollment Mix (Section G) – please provide your estimated distribution of enrollees. This will be used to calculate the statewide composite based on estimated enrollees in the Charter Oak program.
26. Statewide Individual 300% FPL and above Composite Bid (Section H) – this composite bid is calculated by taking the age/sex rates in Section F and multiplying them by the projected enrollment mix in Section G. This premium is targeted to be at \$250 PMPM.
27. Statewide Family Size Factor – The Contractor should supply their estimated family size factor to convert the individual rate to a family rate (subscriber + spouse, subscriber + spouse + child(ren) or subscriber + child(ren)).
28. Statewide Family 300% FPL and Above Composite Bid – The family rate is then calculated from the individual rate (H) multiplied by the family factor (I).
29. Statewide Federal Poverty Level Plan Design Factor (if applicable)- The Contractor can then adjust the individual and family rates to reflect the FPL and plan design for those groups under 300% FPL. Factors can be input to address differences in income, enrollee contributions, deductibles, and out of pocket maximums.
30. ONLY IF NECESSARY – Alternative Program/Plan Design – As noted above, Charter Oak is intended to be a community-rated product with a Target Premium of \$250 PMPM for all individuals with incomes at 300% FPL and above, regardless of age, sex, or geography. If the Contractor is unable to develop a capitation proposal that achieves a premium of \$250 or less, the Contractor is requested to alter the Base Program and Plan Design included within the RFP in such a manner that will achieve the Target Premium of \$250 PMPM. All changes are subject to the approval of DSS and may include altering the program’s rate structure – age/sex or geographic factors, plan design – covered benefits and cost-sharing, and/or program design – eligibility criteria. There is a section on the Alternative Program/Plan Design bid form to supply adjustments to the program/plan design as a percentage of the capitation rate.
31. For Contractors wishing to participate in the HUSKY program, participation in the Charter Oak program is mandatory. Schedule 1 covers both the HUSKY program and

the Charter Oak program cost proposals. Preparer **must** sign, date, and enter the name of the organization preparing the CRCS, the name of the actuary used (if any), and the actuary's firm.

E. Instructions for Completing HUSKY Schedule 2

Please complete the Administrative Cost Detail by Expense Classification and Department type. Note that we have included different departments that may be within the organization. However, if there are other sectors within the organization, please provide those departments under the available "Department #" column and provide a description of the department. Please provide the total dollar amount of administrative expenses paid to a related/affiliated party. In addition, please provide written explanations of any differences between the total administrative expense reported on Schedule 2 and the amounts shown on the HUSKY CRCS rating sheets. The total administrative cost from Schedule 2 must be consistent with the administrative PMPM amounts entered on the HUSKY CRCS forms when converted to a total dollar amount across all rating groups combined.

F. Instructions for Completing HUSKY Schedule 3

If the MCO contracts with providers on a capitated basis, please complete the supplemental schedule for each service provider that is capitated. Depending on the arrangement with providers, an MCO may either include the entire portion of the capitation payment in a medical expense line, or it may break out a portion of the capitation payment and report that in an administrative expense line. We have included a few services that may be capitated to providers. However, if there are other capitated services, please include these services on the worksheet.

G. Rate Negotiation Process

1. The Department will analyze the Contractor's initial capitation cost bids to determine if clarification is needed and whether rates are within the Department's actuarially sound rate ranges. Rate ranges will not be disclosed. The capitation cost bids are due to the Department on **March 14, 2008. The Contractor is advised to provide in its bids clear, precise information, both narrative and quantitative.**
2. The Department will accept capitation cost bids that are within the actuarially sound rate range. For cost bids that are not within the rate ranges, the Department will respond to all Contractors with an "offer rate" and a final rate package that reflects a rate the Department will accept from the Contractor.
3. The Department will schedule a negotiation meeting with all MCOs to discuss the capitation cost bids. The Department anticipates agreement on final rates during negotiation meeting.
4. If agreement on rates cannot be reached during the negotiation meeting, final rates will be sent to the Contractor within two weeks after the negotiation meeting.

5. Notification of the Contractor's intent to accept or reject the offered rate(s) is TBD.
6. The Department will not contract for any rates outside of the Department's actuarially determined rate ranges.

H. Attachments

1. Cost Proposal Excel File
2. Example of Detailed Narrative
3. Category of Service Descriptions
4. Maternity Supplemental Information Description
5. Newborn Supplemental Information Description

Attachment 1 – Cost Proposal Excel File

Schedule 1
Plan Information Worksheet

HUSKY Program and Charter Oak Program
Cost Proposal

Plan Name: [Plan Name]

Plan Address:

Address 1: [Address 1]

Address 2: [Address 2]

City, State, Zip: [City, State, Zip]

Plan CEO: [CEO name]

Proposal contact name: [Contact name]

Proposal contact title: [Contact title]

Proposal contact phone #: [Contact phone]

Proposal contact e-mail: [Contact e-mail]

Fax Number: [Contact fax]

Actuary used (if any): [Actuary name]

Actuary phone #: [Actuary phone]

Certification Statement:

We hereby affirm that the information in this premium proposal rate application including all schedules and exhibits thereto, has been prepared in accordance with the most recent instructions of the State of Connecticut Department of Social Services and to the best of our knowledge and belief is accurate and complete.

[Signature area]

Signature, Chief Executive Officer

[Date area]

Date

[Signature area]

Signature, Actuary (if used)

[Date area]

Date

Health Plan Name: [Plan Name]
 Rating Period: 7/1/2008 to 6/30/2009
 Rating Group: HUSKY A – TANF less than 1 year old
 Rating Region: Statewide
 Estimated Member Months:

Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost ¹	Rating Period PMPM
01 Physical Health – Inpatient Hospital	Days	\$ _____	_____	\$ _____	\$ -
02 Physical Health – Outpatient Hospital Non-Emergent	Visits	\$ _____	_____	\$ _____	\$ -
03 Outpatient Hospital – Emergency	Visits	\$ _____	_____	\$ _____	\$ -
04 Physician – Primary Care	Visits	\$ _____	_____	\$ _____	\$ -
05 Physician – Specialty Care	Visits	\$ _____	_____	\$ _____	\$ -
06 Emergency Transportation	One-way trips	\$ _____	_____	\$ _____	\$ -
07 Non-Emergency Transportation	One-way trips	\$ _____	_____	\$ _____	\$ -
08 Lab/Radiology	Procedures	\$ _____	_____	\$ _____	\$ -
09 Durable Medical Equipment	Services	\$ _____	_____	\$ _____	\$ -
10 Vision	Services	\$ _____	_____	\$ _____	\$ -
11 Other (Total of a through e)					\$ -
a)				\$ _____	\$ -
b)				\$ _____	\$ -
c)				\$ _____	\$ -
d)				\$ _____	\$ -
e)				\$ _____	\$ -
12 Total Medical Expenses					\$ -
Less					
13 Third Party Liability Recovery (enter as a negative value)					\$ -
14 Reinsurance Recoveries (enter as a negative value)					\$ -
15 Net Medical Expenses					\$ -
16 Reinsurance Premium					\$ -
17 Administration (from Schedule 2) ²				% of Premium 0.00%	\$ -
18 Underwriting Gain				0.00%	\$ -
19 Risk/Contingency				0.00%	\$ -
20 Total Capitation Rate					\$ -
21 Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

Health Plan Name: [Plan Name]
 Rating Period: 7/1/2008 to 6/30/2009
 Rating Group: HUSKY A – TANF Age 1-14 M&F
 Rating Region: Statewide
 Estimated Member Months:

Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost ¹	Rating Period PMPM
01 Physical Health – Inpatient Hospital	Days	\$ _____	_____	\$ _____	\$ -
02 Physical Health – Outpatient Hospital Non-Emergent	Visits	\$ _____	_____	\$ _____	\$ -
03 Outpatient Hospital – Emergency	Visits	\$ _____	_____	\$ _____	\$ -
04 Physician – Primary Care	Visits	\$ _____	_____	\$ _____	\$ -
05 Physician – Specialty Care	Visits	\$ _____	_____	\$ _____	\$ -
06 Emergency Transportation	One-way trips	\$ _____	_____	\$ _____	\$ -
07 Non-Emergency Transportation	One-way trips	\$ _____	_____	\$ _____	\$ -
08 Lab/Radiology	Procedures	\$ _____	_____	\$ _____	\$ -
09 Durable Medical Equipment	Services	\$ _____	_____	\$ _____	\$ -
10 Vision	Services	\$ _____	_____	\$ _____	\$ -
11 Other (Total of a through e)				\$ _____	\$ -
a)			_____	\$ _____	\$ -
b)			_____	\$ _____	\$ -
c)			_____	\$ _____	\$ -
d)			_____	\$ _____	\$ -
e)			_____	\$ _____	\$ -
12 Total Medical Expenses					\$ -
Less					
13 Third Party Liability Recovery (enter as a negative value)					\$ -
14 Reinsurance Recoveries (enter as a negative value)					\$ -
15 Net Medical Expenses					\$ -
16 Reinsurance Premium					\$ -
				% of Premium	
17 Administration (from Schedule 2) ²				0.0%	\$ -
18 Underwriting Gain				0.0%	\$ -
19 Risk/Contingency				0.0%	\$ -
20 Total Capitation Rate					\$ -
21 Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

Health Plan Name: [Plan Name]
 Rating Period: 7/1/2008 to 6/30/2009
 Rating Group: HUSKY A – SSI Age 0-20 M&F
 Rating Region: Statewide
 Estimated Member Months:

Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost ¹	Rating Period PMPM
01 Physical Health – Inpatient Hospital	Days	\$ _____	_____	\$ _____	\$ -
02 Physical Health – Outpatient Hospital Non-Emergent	Visits	\$ _____	_____	\$ _____	\$ -
03 Outpatient Hospital – Emergency	Visits	\$ _____	_____	\$ _____	\$ -
04 Physician – Primary Care	Visits	\$ _____	_____	\$ _____	\$ -
05 Physician – Specialty Care	Visits	\$ _____	_____	\$ _____	\$ -
06 Emergency Transportation	One-way trips	\$ _____	_____	\$ _____	\$ -
07 Non-Emergency Transportation	One-way trips	\$ _____	_____	\$ _____	\$ -
08 Lab/Radiology	Procedures	\$ _____	_____	\$ _____	\$ -
09 Durable Medical Equipment	Services	\$ _____	_____	\$ _____	\$ -
10 Vision	Services	\$ _____	_____	\$ _____	\$ -
11 Other (Total of a through e)					\$ -
a)				\$ _____	\$ -
b)				\$ _____	\$ -
c)				\$ _____	\$ -
d)				\$ _____	\$ -
e)				\$ _____	\$ -
12 Total Medical Expenses					\$ -
Less					
13 Third Party Liability Recovery (enter as a negative value)					\$ -
14 Reinsurance Recoveries (enter as a negative value)					\$ -
15 Net Medical Expenses					\$ -
16 Reinsurance Premium					\$ -
				% of Premium	
17 Administration (from Schedule 2) ²				0.0%	\$ -
18 Underwriting Gain				0.0%	\$ -
19 Risk/Contingency				0.0%	\$ -
20 Total Capitation Rate					\$ -
21 Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

Health Plan Name: [Plan Name]
 Rating Period: 7/1/2008 to 6/30/2009
 Rating Group: HUSKY A – DCF Age 0-20 M&F
 Rating Region: Statewide
 Estimated Member Months:

Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost ¹	Rating Period PMPM
01 Physical Health – Inpatient Hospital	Days	\$		\$	\$ -
02 Physical Health – Outpatient Hospital Non-Emergent	Visits	\$		\$	\$ -
03 Outpatient Hospital – Emergency	Visits	\$		\$	\$ -
04 Physician – Primary Care	Visits	\$		\$	\$ -
05 Physician – Specialty Care	Visits	\$		\$	\$ -
06 Emergency Transportation	One-way trips	\$		\$	\$ -
07 Non-Emergency Transportation	One-way trips	\$		\$	\$ -
08 Lab/Radiology	Procedures	\$		\$	\$ -
09 Durable Medical Equipment	Services	\$		\$	\$ -
10 Vision	Services	\$		\$	\$ -
11 Other (Total of a through e)					\$ -
a)				\$	\$ -
b)				\$	\$ -
c)				\$	\$ -
d)				\$	\$ -
e)				\$	\$ -
12 Total Medical Expenses					\$ -
Less					
13 Third Party Liability Recovery (enter as a negative value)					\$ -
14 Reinsurance Recoveries (enter as a negative value)					\$ -
15 Net Medical Expenses					\$ -
16 Reinsurance Premium					\$ -
17 Administration (from Schedule 2) ²				% of Premium 0.0%	\$ -
18 Underwriting Gain				0.0%	\$ -
19 Risk/Contingency				0.0%	\$ -
20 Total Capitation Rate					\$ -
21 Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

Health Plan Name: [Plan Name]
 Rating Period: 7/1/2008 to 6/30/2009
 Rating Group: HUSKY A – TANF Age 15-40 Female
 Rating Region: Statewide
 Estimated Member Months:

Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost ¹	Rating Period PMPM
01 Physical Health – Inpatient Hospital	Days	\$		\$	\$ -
02 Physical Health – Outpatient Hospital Non-Emergent	Visits	\$		\$	\$ -
03 Outpatient Hospital – Emergency	Visits	\$		\$	\$ -
04 Physician – Primary Care	Visits	\$		\$	\$ -
05 Physician – Specialty Care	Visits	\$		\$	\$ -
06 Emergency Transportation	One-way trips	\$		\$	\$ -
07 Non-Emergency Transportation	One-way trips	\$		\$	\$ -
08 Lab/Radiology	Procedures	\$		\$	\$ -
09 Durable Medical Equipment	Services	\$		\$	\$ -
10 Vision	Services	\$		\$	\$ -
11 Other (Total of a through e)					\$ -
a)				\$	\$ -
b)				\$	\$ -
c)				\$	\$ -
d)				\$	\$ -
e)				\$	\$ -
12 Total Medical Expenses					\$ -
Less					
13 Third Party Liability Recovery (enter as a negative value)					\$ -
14 Reinsurance Recoveries (enter as a negative value)					\$ -
15 Net Medical Expenses					\$ -
16 Reinsurance Premium					\$ -
				% of Premium	
17 Administration (from Schedule 2) ²				0.0%	\$ -
18 Underwriting Gain				0.0%	\$ -
19 Risk/Contingency				0.0%	\$ -
20 Total Capitation Rate					\$ -
21 Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

Health Plan Name: [Plan Name]
 Rating Period: 7/1/2008 to 6/30/2009
 Rating Group: HUSKY A – TANF Age 15-40 Male
 Rating Region: Statewide
 Estimated Member Months:

Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost ¹	Rating Period PMPM
01 Physical Health – Inpatient Hospital	Days	\$		\$	\$ -
02 Physical Health – Outpatient Hospital Non-Emergent	Visits	\$		\$	\$ -
03 Outpatient Hospital – Emergency	Visits	\$		\$	\$ -
04 Physician – Primary Care	Visits	\$		\$	\$ -
05 Physician – Specialty Care	Visits	\$		\$	\$ -
06 Emergency Transportation	One-way trips	\$		\$	\$ -
07 Non-Emergency Transportation	One-way trips	\$		\$	\$ -
08 Lab/Radiology	Procedures	\$		\$	\$ -
09 Durable Medical Equipment	Services	\$		\$	\$ -
10 Vision	Services	\$		\$	\$ -
11 Other (Total of a through e)					\$ -
a)				\$	\$ -
b)				\$	\$ -
c)				\$	\$ -
d)				\$	\$ -
e)				\$	\$ -
12 Total Medical Expenses					\$ -
Less					
13 Third Party Liability Recovery (enter as a negative value)					\$ -
14 Reinsurance Recoveries (enter as a negative value)					\$ -
15 Net Medical Expenses					\$ -
16 Reinsurance Premium					\$ -
				% of Premium	
17 Administration (from Schedule 2) ²				0.0%	\$ -
18 Underwriting Gain				0.0%	\$ -
19 Risk/Contingency				0.0%	\$ -
20 Total Capitation Rate					\$ -
21 Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

Health Plan Name:	[Plan Name]
Rating Period:	7/1/2008 to 6/30/2009
Rating Group:	HUSKY A – TANF Age 40+ M&F
Rating Region:	Statewide
Estimated Member Months:	

Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost ¹	Rating Period PMPM
01 Physical Health – Inpatient Hospital	Days	\$ _____	_____	\$ _____	\$ -
02 Physical Health – Outpatient Hospital Non-Emergent	Visits	\$ _____	_____	\$ _____	\$ -
03 Outpatient Hospital – Emergency	Visits	\$ _____	_____	\$ _____	\$ -
04 Physician – Primary Care	Visits	\$ _____	_____	\$ _____	\$ -
05 Physician – Specialty Care	Visits	\$ _____	_____	\$ _____	\$ -
06 Emergency Transportation	One-way trips	\$ _____	_____	\$ _____	\$ -
07 Non-Emergency Transportation	One-way trips	\$ _____	_____	\$ _____	\$ -
08 Lab/Radiology	Procedures	\$ _____	_____	\$ _____	\$ -
09 Durable Medical Equipment	Services	\$ _____	_____	\$ _____	\$ -
10 Vision	Services	\$ _____	_____	\$ _____	\$ -
11 Other (Total of a through e)					\$ -
a)				\$ _____	\$ -
b)				\$ _____	\$ -
c)				\$ _____	\$ -
d)				\$ _____	\$ -
e)				\$ _____	\$ -
12 Total Medical Expenses					\$ -
Less					
13 Third Party Liability Recovery (enter as a negative value)					\$ -
14 Reinsurance Recoveries (enter as a negative value)					\$ -
15 Net Medical Expenses					\$ -
16 Reinsurance Premium					\$ -
				% of Premium	
17 Administration (from Schedule 2) ²				0.0%	\$ -
18 Underwriting Gain				0.0%	\$ -
19 Risk/Contingency				0.0%	\$ -
20 Total Capitation Rate					\$ -
21 Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

Health Plan Name: [Plan Name]
 Rating Period: 7/1/2008 to 6/30/2009
 Rating Group: HUSKY B – Band 1 (185% to 235% FPL) All Ages
 Rating Region: Statewide
 Estimated Member Months:

Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost ¹	Rating Period PMPM
01 Physical Health – Inpatient Hospital	Days	\$ _____	_____	\$ _____	\$ -
02 Physical Health – Outpatient Hospital Non-Emergent	Visits	\$ _____	_____	\$ _____	\$ -
03 Outpatient Hospital – Emergency	Visits	\$ _____	_____	\$ _____	\$ -
04 Physician – Primary Care	Visits	\$ _____	_____	\$ _____	\$ -
05 Physician – Specialty Care	Visits	\$ _____	_____	\$ _____	\$ -
06 Emergency Transportation	One-way trips	\$ _____	_____	\$ _____	\$ -
07 Non-Emergency Transportation	One-way trips	\$ _____	_____	\$ _____	\$ -
08 Lab/Radiology	Procedures	\$ _____	_____	\$ _____	\$ -
09 Durable Medical Equipment	Services	\$ _____	_____	\$ _____	\$ -
10 Vision	Services	\$ _____	_____	\$ _____	\$ -
11 Other (Total of a through e)					\$ -
a)				\$ _____	\$ -
b)				\$ _____	\$ -
c)				\$ _____	\$ -
d)				\$ _____	\$ -
e)				\$ _____	\$ -
12 Total Medical Expenses					\$ -
Less					
13 Third Party Liability Recovery (enter as a negative value)					\$ -
14 Reinsurance Recoveries (enter as a negative value)					\$ -
15 Net Medical Expenses					\$ -
16 Reinsurance Premium					\$ -
				% of Premium	
17 Administration (from Schedule 2) ²				0.0%	\$ -
18 Underwriting Gain				0.0%	\$ -
19 Risk/Contingency				0.0%	\$ -
20 Total Capitation Rate					\$ -
21 Medical Loss Ratio					#DIV/0!

Notes:
 1 Unit Cost should be expressed net of any copay amounts
 2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

Health Plan Name:	[Plan Name]
Rating Period:	7/1/2008 to 6/30/2009
Rating Group:	HUSKY B – Band 2 (235% to 300% FPL) All Ages
Rating Region:	Statewide
Estimated Member Months:	

Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost ¹	Rating Period PMPM
01 Physical Health – Inpatient Hospital	Days	\$ _____	_____	\$ _____	\$ -
02 Physical Health – Outpatient Hospital Non-Emergent	Visits	\$ _____	_____	\$ _____	\$ -
03 Outpatient Hospital – Emergency	Visits	\$ _____	_____	\$ _____	\$ -
04 Physician – Primary Care	Visits	\$ _____	_____	\$ _____	\$ -
05 Physician – Specialty Care	Visits	\$ _____	_____	\$ _____	\$ -
06 Emergency Transportation	One-way trips	\$ _____	_____	\$ _____	\$ -
07 Non-Emergency Transportation	One-way trips	\$ _____	_____	\$ _____	\$ -
08 Lab/Radiology	Procedures	\$ _____	_____	\$ _____	\$ -
09 Durable Medical Equipment	Services	\$ _____	_____	\$ _____	\$ -
10 Vision	Services	\$ _____	_____	\$ _____	\$ -
11 Other (Total of a through e)				\$ _____	\$ -
a)			_____	\$ _____	\$ -
b)			_____	\$ _____	\$ -
c)			_____	\$ _____	\$ -
d)			_____	\$ _____	\$ -
e)			_____	\$ _____	\$ -
12 Total Medical Expenses					\$ -
Less					
13 Third Party Liability Recovery (enter as a negative value)					\$ -
14 Reinsurance Recoveries (enter as a negative value)					\$ -
15 Net Medical Expenses					\$ -
16 Reinsurance Premium					\$ -
				% of Premium	
17 Administration (from Schedule 2) ²				0.0%	\$ -
18 Underwriting Gain				0.0%	\$ -
19 Risk/Contingency				0.0%	\$ -
20 Total Capitation Rate					\$ -
21 Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

Health Plan Name: [Plan Name]
 Rating Period: 7/1/2008 to 6/30/2009
 Rating Group: HUSKY B – Band 2 (Over 300% FPL) All Ages
 Rating Region: Statewide
 Estimated Member Months:

Category of Service	Unit Description	Copay Amount	Utilization per 1,000	Net Unit Cost ¹	Rating Period PMPM
01 Physical Health – Inpatient Hospital	Days	\$		\$	\$ -
02 Physical Health – Outpatient Hospital Non-Emergent	Visits	\$		\$	\$ -
03 Outpatient Hospital – Emergency	Visits	\$		\$	\$ -
04 Physician – Primary Care	Visits	\$		\$	\$ -
05 Physician – Specialty Care	Visits	\$		\$	\$ -
06 Emergency Transportation	One-way trips	\$		\$	\$ -
07 Non-Emergency Transportation	One-way trips	\$		\$	\$ -
08 Lab/Radiology	Procedures	\$		\$	\$ -
09 Durable Medical Equipment	Services	\$		\$	\$ -
10 Vision	Services	\$		\$	\$ -
11 Other (Total of a through e)					\$ -
a)				\$	\$ -
b)				\$	\$ -
c)				\$	\$ -
d)				\$	\$ -
e)				\$	\$ -
12 Total Medical Expenses					\$ -
Less					
13 Third Party Liability Recovery (enter as a negative value)					\$ -
14 Reinsurance Recoveries (enter as a negative value)					\$ -
15 Net Medical Expenses					\$ -
16 Reinsurance Premium					\$ -
17 Administration (from Schedule 2) ²				% of Premium 0.0%	\$ -
18 Underwriting Gain				0.0%	\$ -
19 Risk/Contingency				0.0%	\$ -
20 Total Capitation Rate					\$ -
21 Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extend such a provision is deemed beneficial to the State.

Health Plan Name:
 Rating Period:
 Rating Group:
 Rating Region:
 Estimated Number of Deliveries:
 Percentage C-Section Deliveries:

[Plan Name]
7/1/2008 to 6/30/2009
Supplemental Maternity
Statewide

Category of Service	Unit Description	Copay Amount	Vaginal Delivery Type			C-Section Delivery Type			All Delivery Types		
			Units per 1000 Deliveries	Net Unit Cost ¹	Rating Period Cost per Delivery	Units per 1000 Deliveries	Net Unit Cost ¹	Rating Period Cost per Delivery	Units per 1000 Deliveries	Net Unit Cost ¹	Rating Period Cost per Delivery
01 Physical Health – Inpatient Hospital	Days	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -
02 Physical Health – Outpatient Hospital Non-Emergent	Visits	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -
03 Outpatient Hospital – Emergency	Visits	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -
04 Physician – Primary Care	Visits	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -
05 Physician – Specialty Care	Visits	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -
06 Emergency Transportation	One-way trips	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -
07 Non-Emergency Transportation	One-way trips	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -
08 Lab/Radiology	Procedures	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -
09 Durable Medical Equipment	Services	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -
10 Vision	Services	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -
11 Other (Total of a through e)											
a)				\$ -	\$ -		\$ -	\$ -	-	\$ -	\$ -
b)				\$ -	\$ -		\$ -	\$ -	-	\$ -	\$ -
c)				\$ -	\$ -		\$ -	\$ -	-	\$ -	\$ -
d)				\$ -	\$ -		\$ -	\$ -	-	\$ -	\$ -
e)				\$ -	\$ -		\$ -	\$ -	-	\$ -	\$ -
12 Total Medical Expenses					\$ -			\$ -			\$ -
Less											
13 Third Party Liability Recovery (enter as a negative value)					\$ -			\$ -			\$ -
14 Reinsurance Recoveries (enter as a negative value)					\$ -			\$ -			\$ -
15 Net Medical Expenses					\$ -			\$ -			\$ -
16 Reinsurance Premium					\$ -			\$ -			\$ -
17 Administration (from Schedule 2) ²				% of Premium	\$ -		% of Premium	\$ -		% of Premium	\$ -
18 Underwriting Gain				0.0%	\$ -		0.0%	\$ -		#DIV/0!	\$ -
19 Risk/Contingency				0.0%	\$ -		0.0%	\$ -		#DIV/0!	\$ -
20 Total Capitation Rate					\$ -			\$ -			\$ -
21 Medical Loss Ratio					#DIV/0!			#DIV/0!			#DIV/0!

Notes:

¹ Unit Cost should be expressed net of any copay amounts

² While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

Health Plan Name: [Plan Name]
 Rating Period: 7/1/2008 to 6/30/2009
 Rating Group: Supplemental Newborn
 Rating Region: Statewide
 Estimated Number of Births:
 Percentage Stillborn:
 Percentage Multiples:

Category of Service	Unit Description	Copay Amount	Units per 1000 Births	Net Unit Cost ¹	Rating Period Cost per Birth
01 Physical Health – Inpatient Hospital	Days	\$		\$	\$ -
02 Physical Health – Outpatient Hospital Non-Emergent	Visits	\$		\$	\$ -
03 Outpatient Hospital – Emergency	Visits	\$		\$	\$ -
04 Physician – Primary Care	Visits	\$		\$	\$ -
05 Physician – Specialty Care	Visits	\$		\$	\$ -
06 Emergency Transportation	One-way trips	\$		\$	\$ -
07 Non-Emergency Transportation	One-way trips	\$		\$	\$ -
08 Lab/Radiology	Procedures	\$		\$	\$ -
09 Durable Medical Equipment	Services	\$		\$	\$ -
10 Vision	Services	\$		\$	\$ -
11 Other (Total of a through e)					\$ -
a)				\$	\$ -
b)				\$	\$ -
c)				\$	\$ -
d)				\$	\$ -
e)				\$	\$ -
12 Total Medical Expenses					\$ -
Less					
13 Third Party Liability Recovery (enter as a negative value)					\$ -
14 Reinsurance Recoveries (enter as a negative value)					\$ -
15 Net Medical Expenses					\$ -
16 Reinsurance Premium					\$ -
				% of Premium	
17 Administration (from Schedule 2) ²				0.0%	\$ -
18 Underwriting Gain				0.0%	\$ -
19 Risk/Contingency				0.0%	\$ -
20 Total Capitation Rate					\$ -
21 Medical Loss Ratio					#DIV/0!

Notes:

1 Unit Cost should be expressed net of any copay amounts

2 While DSS currently does not have specific MLR requirements included as part of this RFP, DSS reserves the right to include such requirements at a later date to the extent such a provision is deemed beneficial to the State.

Schedule 2: Administrative Cost Detail
 Contract Year 1 - July 1, 2008 through June 30, 2009

ADMINISTRATIVE COST DETAIL																
Expense Classification		General & Operations	Finance	Claims Processing	Information Systems	Pharmacy Administration	Network Development	Member & Enrollment Services	Case Management	Disease Management	Utilization Management	Other Medical Management	Department #	Department #	Department #	Total
1	Compensation	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
2	Interest Expense	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
3	Occupancy, Depreciation & Amortization	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
4	Education & Outreach	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
5	Marketing	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
6	Other	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
7	TOTAL	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other Charges Detailed Breakdown Description (insert additional rows if needed)																
Other Charges Detailed Breakdown Description (insert additional rows if needed)		General & Operations	Finance	Claims Processing	Information Systems	Pharmacy Administration	Network Development	Member & Enrollment Services	Case Management	Disease Management	Utilization Management	Other Medical Management	Department #	Department #	Department #	Total
10	Corporate Overhead Allocations	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
11	Subcontracted/Delegated Admin Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
12	Management Fees	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
13		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
14		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
15		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
16		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
17		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
18		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
19		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
20	TOTAL	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Total related/affiliated Party expenses:

Notes:

1 Blue highlighted cells denote data input by the MCO

2 Gray highlighted cells denote calculation

3 Other expense allocations must be detailed so that no other expense classification exceeds \$250,000

Schedule 3: Capitation Arrangements
Contract Year 1 - July 1, 2008 through June 30, 2009

SUBCAPITATED SERVICES				
Covered Service		Provider at Full-Risk (Yes or No)	Total Amount Reported as Medical Expense	Total Amount Reported as Administrative Expense
1	Global Capitation		\$ -	\$ -
2	Vision		\$ -	\$ -
3	Lab/Radiology		\$ -	\$ -
5	Transportation		\$ -	\$ -
6	Triage Services/Nurse Hotline		\$ -	\$ -
7	Primary Care Physicians		\$ -	\$ -
8	Other #1		\$ -	\$ -
9	Other #2		\$ -	\$ -
10	Other #3		\$ -	\$ -
11	Other #4		\$ -	\$ -
12	Other #5		\$ -	\$ -
13	Other #6		\$ -	\$ -
14	Other #7		\$ -	\$ -
15	Total		\$ -	\$ -

Note:

1 Blue highlighted cells denote data input by the MCO

Instructions for filling out Charter Oak Bid Form

PLEASE NOTE: Charter Oak is intended to be a community-rated product with a Target Premium of \$250 per member per month (PMPM) for all individuals, regardless of age, sex, or geography. Family rates will be a single statewide composite rate using a Family Rating Factor provided by the MCO. This template builds the Target Premium Rate for individuals with incomes 300% and Above. Rates for individuals and families with incomes less than 300% FPL can be adjusted if necessary using FPL factors provided by the Contractor.

Step 1 Be aware that you may enter values only in the light blue highlighted areas (where the text font is also blue). All other areas are locked, whether text or formulas. Since you cannot insert new rows or columns in this file, if you need to provide additional Excel material, you may do so as separate addenda, but note that the bid forms in this file will be the basis of bid evaluation. Also, you are required to submit a **methodology write-up** corresponding to the completed bid forms. This needs to describe your data sources, time periods, nature of each adjustment or estimate, and methodology for calculating each of them.

If the Contractor is unable to provide a Premium rate of \$250 using the Base Plan Design provided in the RFP, Contractors are requested to submit a Bid Form based on an alternative program/plan design that achieves the Target Premium of \$250. Alternative program/plans designs could include varying the benefits covered, the cost-sharing requirements or the rate structure (age/sex rating and/or geographic rating). To the extent possible, please describe the alternative program/plan design changes in cells M45-P55. Please provide additional sheets supporting the alternative program/plan design if necessary.

A. Average PMPM Development

Step 2 Confirm your Contractor name in cell C1. Contractor should input estimated member months for this program in cell C4.

Step 3 Enter your base claims experience by Categories of Service (COS) in B9-B24. For ease of bid development, we have included the COS used in the HUSKY development. Please provide further detail, if necessary, for the "Other" categories in lines 11a-c. Although the Contractor is not at risk for Pharmacy or Specialty Behavioral Health, please include Pharmacy and Specialty Behavioral Health in the COS in Step 3, as Pharmacy and Specialty Behavioral Health Services are included within the Target Premium of \$250.

Step 4 In cells C9-C24, enter the PMPM claims costs by COS of your starting base data. The date at which these costs are centered should be indicated in cell C7.

Step 5 Use the columns D-K to quantify the PMPM impact (by COS) of separate adjustments (for example: trend, demographics, etc.) to the base data to estimate PMPM claims costs in SFY09 (centered at 01/01/09). Document the nature of each adjustment and their calculation approach in your methodology description. Step #5 will result in an automatic calculation of the Total Medical PMPM (B) in cell L25.

Step 6 In columns M and N, provide the annual utilization per thousand and unit cost components (by COS) of your SFY09 projected PMPM claims costs.

Step 7 If cells P9-P24 do not indicate "OK", please revisit your previous entries to ensure that your SFY09 PMPM projection of utilization and unit cost levels is consistent with the adjustments build-up.

B. Total Medical Expenses

This cell will be automatically calculated as the sum of the medical costs PMPMs in columns L & O.

Step 8 In cell L27, provide the TPL/COB recoveries (as a negative value) expected for Charter Oak.

C. Non-Medical Costs

Step 9 In cells K33-K35, indicate your projected SFY09 PMPM administration, underwriting gain, and risk/contingency loading percentages.

D. Total Capitation Rate (B + C)

This cell will be automatically calculated as the sum of the medical costs PMPMs and admin/gain/risk in columns L.

MLR: Note that while DSS does not currently have an MLR requirement, DSS reserves the right to establish an MLR requirement for the Charter Oak program in the future.

E. Age/Sex Factors

Step 10 In cells C44-C59, provide the age/sex claims cost relativities (relative to the average PMPM claims cost in cell L25), typically referred to as age/sex factors.

F. Implied Age/Sex Bid Rates for SFY09 = (BxE)+C OR F. Age/Sex Bid Rates for SFY09 = (BxE)+C for Alternative Plan Design

Note that cells G44-G59 get calculated automatically and are representative ONLY for the Base Program/Plan Design. Charter Oak is intended to be a community rated product using one rate for individuals and one rate for families. MCOs may propose utilizing this section of the bid form, if necessary, for the submission of an alternative program/plan design to achieve the Target Premium of \$250.

G. Projected Enrollment Mix

Step 11 Projected mix of SFY09 enrollment. Please provide your projected enrollment mix by age/sex category based on the program/plan design included within the RFP. If you include an alternative Program/Plan Design, please provide your projected enrollment mix by age/sex category based on the alternative program/plan design.

H. Statewide Individual 300% FPL and Above Composite Bid = sumproduct (FxG)

This cell is automatically calculated and represents the contractor's proposed premium rate for individuals in the Charter Oak program. DSS will compare this figure to the Target Premium of \$250 for Charter Oak.

I. Statewide Family Size Factor

Step 12 Please input your Family Size Factor to convert the individual rate to a family rate.

J. Statewide Family 300% FPL and Above Composite Bid = sumproduct (HxI)

This cell is automatically calculated and represents the MCOs proposed premium rate for families in the Charter Oak program.

K. Statewide Federal Poverty Level Plan Design Factor (HxK for Individual and JxK for Family)

Step 13 Due to variances in the deductible and out-of-pocket maximums by FPL level, Contractors may vary their premium requested of DSS by FPL level. Please input your FPL Plan Design Factors in cells K72-K75. The Individual and Family rates will be calculated automatically by FPL.

Final factors and all resulting rates are subject to approval by DSS and may be subject to Federal standards for actuarial soundness.

Contractor Name: [Plan Name]
 Rating Period: 7/1/2008 to 6/30/2009
 Rating Group: Charter Oak Base RFP Plan Design
 Estimated Member Months:

A. Average PMPM Development													SFY09 centered at 01/01/09		
Category of Service	PMPM Cost	Trend	Co-Pay	Ded	OOP Max	Plan Design	Adj x (Describe)	Adj x (Describe)	Adj x (Describe)	PMPM Cost	Unit Description	Annual Utilization per 1,000 members	Unit Cost	PMPM Cost	
01	Physical Health – Inpatient Hospital	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Days	-	\$ -	\$ -	OK
02	Physical Health – Outpatient Hospital Non-Emergent	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Visits	-	\$ -	\$ -	OK
03	Outpatient Hospital – Emergency	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Visits	-	\$ -	\$ -	OK
04	Physician – Primary Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Visits	-	\$ -	\$ -	OK
05	Physician – Specialty Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Visits	-	\$ -	\$ -	OK
06	Emergency Transportation	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	One-way trips	-	\$ -	\$ -	OK
07	Non-Emergency Transportation (Not covered in Charter Oak)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	One-way trips	-	\$ -	\$ -	OK
08	Lab/Radiology	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Procedures	-	\$ -	\$ -	OK
09	Durable Medical Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Services	-	\$ -	\$ -	OK
10	Vision	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Services	-	\$ -	\$ -	OK
11	Other (Total of a through e)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		-	\$ -	\$ -	OK
a)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		-	\$ -	\$ -	OK
b)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		-	\$ -	\$ -	OK
c)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		-	\$ -	\$ -	OK
	Pharmacy (Carved out, MCO not a risk)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Prescriptions	-	\$ -	\$ -	OK
	Specialty Behavioral Health (Carved out, MCO not at risk)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Services	-	\$ -	\$ -	OK
12	B. Total Medical Expenses	\$ -												\$ -	
Less															
13	Third Party Liability Recovery (enter as a negative value)	\$ -												\$ -	
14	Reinsurance Recoveries (Not Applicable to Charter Oak)	\$ -												\$ -	
15	Net Medical Expenses	\$ -												\$ -	
16	Reinsurance Premium (Not Applicable to Charter Oak)	\$ -												\$ -	
17	Administration (from Schedule 2)										% of Premium			\$ -	
18	Underwriting Gain										0.0%			\$ -	
19	Risk/Contingency										0.0%			\$ -	
	C. Non-Medical Costs													\$ -	
20	D. Total Capitation Rate (B + C)													\$ -	
21	Medical Loss Ratio													0%	

	Individual
19-29 M	-
19-29 F	-
30-34 M	-
30-34 F	-
35-39 M	-
30-39 F	-
40-44 M	-
40-44 F	-
45-49 M	-
45-49 F	-
50-54 M	-
50-54 F	-
55-59 M	-
55-59 F	-
60+ M	-
60+ F	-

- Notes:
 1. Costs are gross and should not include any privately purchased reinsurance
 2. Bid does not include costs for additional benefits provided to enrollees (e.g., chiropractic)
 3. MCO's will input items in blue highlight and other fields will be calculated.

	Statewide	Individual
19-29 M	\$ -	-
19-29 F	\$ -	-
30-34 M	\$ -	-
30-34 F	\$ -	-
35-39 M	\$ -	-
30-39 F	\$ -	-
40-44 M	\$ -	-
40-44 F	\$ -	-
45-49 M	\$ -	-
45-49 F	\$ -	-
50-54 M	\$ -	-
50-54 F	\$ -	-
55-59 M	\$ -	-
55-59 F	\$ -	-
60+ M	\$ -	-
60+ F	\$ -	-

	Statewide	Individual
19-29 M	-	-
19-29 F	-	-
30-34 M	-	-
30-34 F	-	-
35-39 M	-	-
30-39 F	-	-
40-44 M	-	-
40-44 F	-	-
45-49 M	-	-
45-49 F	-	-
50-54 M	-	-
50-54 F	-	-
55-59 M	-	-
55-59 F	-	-
60+ M	-	-
60+ F	-	-

H. Statewide Individual 300% FPL and Above Composite Bid = sumproduct (FxG)
 \$ - TARGET PREMIUM = \$250

I. Statewide Family Size Factor
 0.00

J. Statewide Family 300% FPL and Above Composite Bid = sumproduct (HxI)
 \$ -

K. Statewide Federal Poverty Level Plan Design Factor (HxK for Individual and JxK for Family)

	Individual	Family
0-150% FPL	0.00	\$ -
151-185% FPL	0.00	\$ -
186-235% FPL	0.00	\$ -
236-300% FPL	0.00	\$ -
300% and Above	\$ -	\$ -

Contractor Name:
 Rating Period:
 Rating Group:
 Estimated Member Months:

[Plan Name]
 7/1/2008 to 6/30/2009
 Charter Oak Alternative Program/Plan Design

A. Average PMPM Development														
Category of Service	Base Data centered at mm/dd/yy	Adjustments (expressed as PMPMs, not %)									SFY09 centered at 01/01/09			
	PMPM Cost	Trend	Co-Pay	Ded	OOP Max	Plan Design	Adj x (Describe)	Adj x (Describe)	Adj x (Describe)	PMPM Cost	Unit Description	Annual Utilization per 1,000 members	Unit Cost	PMPM Cost
01 Physical Health – Inpatient Hospital	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Days	-	\$ -	OK
02 Physical Health – Outpatient Hospital Non-Emergent	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Visits	-	\$ -	OK
03 Outpatient Hospital – Emergency	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Visits	-	\$ -	OK
04 Physician – Primary Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Visits	-	\$ -	OK
05 Physician – Specialty Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Visits	-	\$ -	OK
06 Emergency Transportation	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	One-way trips	-	\$ -	OK
07 Non-Emergency Transportation (Not Covered in Charter Oak)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	One-way trips	-	\$ -	OK
08 Lab/Radiology	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Procedures	-	\$ -	OK
09 Durable Medical Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Services	-	\$ -	OK
10 Vision	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Services	-	\$ -	OK
11 Other (Total of a through c)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		-	\$ -	OK
a)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		-	\$ -	OK
b)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		-	\$ -	OK
c)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		-	\$ -	OK
Pharmacy (Carved out, MCO not a risk)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Prescriptions	-	\$ -	OK
Specialty Behavioral Health (Carved out, MCO not a risk)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	Services	-	\$ -	OK
12 B. Total Medical Expenses	\$ -												\$ -	
Less														
13 Third Party Liability Recovery (enter as a negative value)	\$ -													
14 Reinsurance Recoveries (Not Applicable to Charter Oak)	\$ -													
15 Net Medical Expenses	\$ -													
16 Reinsurance Premium (Not Applicable to Charter Oak)	\$ -													
17 Administration (from Schedule 2)										% of Premium				
18 Underwriting Gain										0.0%				
19 Risk/Contingency										0.0%				
C. Non-Medical Costs														
20 D. Total Capitation Rate (B + C)	\$ -													
21 Medical Loss Ratio										0%				

Individual	
19-29 M	-
19-29 F	-
30-34 M	-
30-34 F	-
35-39 M	-
35-39 F	-
40-44 M	-
40-44 F	-
45-49 M	-
45-49 F	-
50-54 M	-
50-54 F	-
55-59 M	-
55-59 F	-
60+ M	-
60+ F	-

Statewide	Individual
19-29 M	\$ -
19-29 F	\$ -
30-34 M	\$ -
30-34 F	\$ -
35-39 M	\$ -
35-39 F	\$ -
40-44 M	\$ -
40-44 F	\$ -
45-49 M	\$ -
45-49 F	\$ -
50-54 M	\$ -
50-54 F	\$ -
55-59 M	\$ -
55-59 F	\$ -
60+ M	\$ -
60+ F	\$ -

Statewide	Individual
19-29 M	-
19-29 F	-
30-34 M	-
30-34 F	-
35-39 M	-
35-39 F	-
40-44 M	-
40-44 F	-
45-49 M	-
45-49 F	-
50-54 M	-
50-54 F	-
55-59 M	-
55-59 F	-
60+ M	-
60+ F	-

Proposed Plan Design Changes	Description	Estimated PMPM Impact as a %
1		0.00%
2		0.00%
3		0.00%
4		0.00%
5		0.00%
6		0.00%
7		0.00%
8		0.00%
9		0.00%
10		0.00%

- Costs are gross and should not include any privately purchased reinsurance
- Bid does not include costs for additional benefits provided to enrollees (e.g., chiropractic)
- MCO's will input items in blue highlight and other fields will be calculated.
- MCO's may alter the rate structure to achieve a \$250 Target Premium and should adjust this sheet accordingly or use an additional spreadsheet.

H. Statewide Individual 300% and Above Composite Bid = sumproduct (F x G) (if applicable)
 \$ - TARGET PREMIUM = \$250

I. Statewide Family Size Factor (if applicable)
 0.00

J. Statewide Family 300% FPL and Above Composite Bid = sumproduct (H x I) (if applicable)
 \$ -

K. Statewide Federal Poverty Level Plan Design Factor (H x K for Individual and J x K for Family) (if applicable)

	Individual	Family
0-150% FPL	0.00	\$ - \$ -
151-185% FPL	0.00	\$ - \$ -
186-235% FPL	0.00	\$ - \$ -
236-300% FPL	0.00	\$ - \$ -
300% and Above	\$ -	\$ -

Attachment 2A – Example of HUSKY Detailed Narrative

July 1, 2008 – June 30, 2009 HUSKY Rate-Setting Methodology

Note: If the rates were not developed in the same manner for each rating group, please fill out a separate form for each methodology used.

1. Data Used:
 - Years
 - Encounter, include any adjustments made
 - Financial, include any adjustments made
 - Other Sources (please explain)

2. Programmatic Changes Incorporated

Item	Description	Rating Group	Category of Service (COS)	Value*

*Include any increases/decreases to other COS that would be impacted by this change.

Recent program changes include:

Benefit Design Changes:

- Effective with dates of service January 1, 2006 and forward, the Managed Care Organizations, or their subcontractors, no longer manage or pay claims for behavioral health services
- Behavioral health services are now authorized and managed under an Administrative Services Organization (ASO) contract with Value Options (VO). VO manages the behavioral health services of HUSKY A, HUSKY B and Department of Children and Families (DCF) funded clients under the CT Behavioral Health Partnership (BHP)
- Elimination of coverage for drugs used for treatment of erectile dysfunction effective January 1, 2006
- Premolar dental sealants are now offered as a covered benefit for children, effective January 1, 2007
- Effective with dates of service July 1, 2008 and forward, the Managed Care Organizations, or their subcontractors, will no longer manage or pay claims for dental services
- Effective with dates of service January 25, 2008 and forward, the Managed Care Organizations, or their subcontractors, will no longer manage or pay claims for pharmacy services

Eligibility Expansions:

- Increase eligibility criteria for parents and needy caretaker relatives of children in HUSKY from 150% FPL to 185% FPL, effective July 1, 2007

- HUSKY coverage provided for all uninsured newborns. State coverage of premium costs for first 4 months of life. Effective July 1, 2007
- Expand HUSKY A eligibility for pregnant women from 185% to 250% FPL, effective January 1, 2008

Medicaid Provider Fee Increases for SFY08:

- Physician (\$27M)
- Clinics (\$10M)
- Dental (\$20M)
- Vision (\$1M)
- Hospitals (\$46M)

3. Managed Care Medical Trend Rate Applied

- Is this a combined utilization and unit cost trend? If not, please supply the above information for both.
- Overall trend: _____%
(from _____ year to 7/1/2008 – 6/30/2009)
- Overall number of trend months used.
- Does trend differ by COS? If so, please provide assumptions.
- Does trend differ by rating group? If so, please provide assumptions.
- Please list trend sources (e.g., financial and encounter data, commercial market, other states' Medicaid programs, etc.).

4. Other Utilization Assumptions – Includes any projected impact of managed care and educational efforts on the utilization rates.

5. Other Unit Cost Assumptions – The Contractor should discuss the nature of its provider fee schedules and any capitated fee arrangements. Providers accepting capitation should be identified. Also, the Contractor should identify any reinsurance, risk sharing, withholds or incentive payment arrangements.

Section 3.47.g of the RFP requires that "Reimbursement by the MCO to all providers shall be at no less than the DEPARTMENT'S Medicaid fee schedule." The current Medicaid fee schedules are available in the bidders' library that can be accessed at www.ct.gov/dss/charteroak and the State's Procurement/Contracting portal at www.das.state.ct.us. The Contractor should describe plans to satisfy Section 3.47.g. The Contractor should describe the data sources that will provide the Department as evidence that the requirements of Section 3.47.g have been met. If the Contractor has capitated arrangements with physicians or hospitals, the Contractor should explain/demonstrate how these capitation arrangements will be structured in order to satisfy Section 3.47.g. Note that the Medicaid fee schedule contains different reimbursement schedules depending on the rendering location (place of service) and type of provider (pediatricians, clinics, federally qualified health clinics (FQHCs), other community physicians). The Contractor should

describe how it proposes to identify such provider types in the data submitted to the Department to ensure that the requirements of Section 3.47.g have been met.

For the maternity supplemental information, if a global fee is used for prenatal and postpartum care services, describe how the fee is modified to account for low utilization or when the onset of care is begun after the first trimester.

6. Enrollment Projections – Discuss the assumptions underlying the enrollment projections and the projected birth rate and maternity delivery rates for each rating group.
7. Reinsurance Premiums and Recoveries – Please provide a copy of the reinsurance contract and details of the reinsurance recovery and premium calculations included on the CRCS projections. Please indicate if the reinsurance contract is with a related/affiliated party and note that any premiums paid to a related/affiliated party in excess of recoveries may require a pay-back to the State.
8. Pro-forma income statements – Provide three years of pro-forma income statements in a format determined by the Contractor that, at a minimum, show total Medicaid membership, revenue, medical expenses, administration expenses and net income/loss.
9. Administrative Contracts and Related Party Charges – Please provide a copy of all administrative services contracts and management agreements (including price page) delegating administrative functions to a third party, indicating those that are with related/affiliated parties. In addition, please provide all contracts with related or affiliated parties applicable during the contract period, the total expected cost and the amount included in the administrative cost projections (Schedule 2) for the contract period. If the MCO does not wish to send contracts, please provide a detailed list of such contracts, the total costs and the amount included in the administrative cost projections (Schedule 2) for the contract period. This should include, but is not limited to:
 - Management services agreement
 - Provider contract changes effecting cost and utilization within the past year
 - Delegated Care Management (CM)/Disease Management (DM) agreements
 - Delegated member/provider services agreements
 - Claims processing agreements
 - Integrated delivery system agreements
 - Agreements for the administration of vision, transportation claims and/or benefits
 - Any other contract with a related or affiliated party for non-medical services or charges
10. Start-Up Costs – The Department recognizes that additional administrative costs exist when an MCO enters into an agreement with a managed care program such

as HUSKY. Identifying each MCO's one-time, non-recurring start-up costs separately from other administrative expenses will allow the Department to review, and if appropriate, address this issue during the bid review process. Any administrative expenses identified in this section must be reasonable and quantifiable. Please provide the following information as it relates to the administration of the HUSKY program.

- A list of non-recurring equipment acquisitions or conversions, included in the administrative cost projections for FY2009
- A list of any planned system conversions, upgrades or initiatives for FY2009, FY2010 or FY2011 and the budgeted cost impact to HUSKY
- Any other applicable information that will help us to understand the equipment and system changes needed to operate the HUSKY program
- Other start-up and acquisition costs and the amount included in the administrative cost projections for FY2009
- If applicable, the allocation method used to assign these costs to the HUSKY program
- The amortization schedule for each component of the expected start-up costs

11. Underwriting Gain and Risk/Contingency Margin. Provide justification for the requested underwriting gain and risk/contingency margin.

12. Other Assumptions – Any other assumptions or information used to prepare the projections.

Attachment 2B – Example of Charter Oak Detailed Narrative

July 1, 2008 – June 30, 2009 Charter Oak Rate-Setting Methodology

Note: If the Contractor submits an Alternative Program/Plan Design bid, please fill out a separate form for the alternative methodology used.

1. Data Used:
 - Years
 - Encounter, include any adjustments made
 - Financial, include any adjustments made
 - Commercial, Medicaid, blending
 - Other Sources (please explain)

2. Programmatic Changes Incorporated

Item	Description	Rating Group	Category of Service (COS)	Value*

*Include any increases/decreases to other COS that would be impacted by this change.

3. Managed Care Medical Trend Rate Applied
 - Is this a combined utilization and unit cost trend? If not, please supply the above information for both.
 - Overall trend: _____%
(from _____ year to 7/1/2008 – 6/30/2009)
 - Overall number of trend months used.
 - Does trend differ by COS? If so, please provide assumptions.
 - Does trend differ by rating group? If so, please provide assumptions.
 - Please list trend sources (e.g., financial and encounter data, commercial market, other states' Medicaid programs, etc.).
4. Other Utilization Assumptions. Includes any projected impact of managed care and educational efforts on the utilization rates.
5. Other Unit Cost Assumptions. The Contractor should discuss the nature of its provider fee schedules and any capitated fee arrangements. Providers accepting capitation should be identified. Also, the Contractor should identify any risk sharing, withholds or incentive payment arrangements.
6. Section 3.47.g of the RFP requires that "Reimbursement by the MCO to all providers shall be at no less than the DEPARTMENT'S Medicaid fee schedule." The current

Medicaid fee schedules are available in the bidders' library that can be accessed at www.ct.gov/dss/charteroak and the State's Procurement/Contracting portal at www.das.state.ct.us. The Contractor should describe plans to satisfy Section 3.47.g. The Contractor should describe the data sources that will provide the Department as evidence that the requirements of Section 3.47.g have been met. If the Contractor has capitated arrangements with physicians or hospitals, the Contractor should explain/demonstrate how these capitation arrangements will be structured in order to satisfy Section 3.47.g. Note that the Medicaid fee schedule contains different reimbursement schedules depending on the rendering location (place of service) and type of provider (pediatricians, clinics, FQHCs, other community physicians). The Contractor should describe how it proposes to identify such provider types in the data submitted to the Department to ensure that the requirements of Section 3.47.g have been met.

7. Enrollment Projections – Discuss the assumptions underlying the enrollment projections and mix by age/sex category for the Charter Oak program.
8. Administrative Contracts and Related Party Charges – Please provide a copy of all administrative services contracts and management agreements (including price page) delegating administrative functions to a third party, indicating those that are with related/affiliated parties. In addition, please provide all contracts with related or affiliated parties applicable during the contract period, the total expected cost and the amount included in the administrative cost projections (Schedule 2) for the contract period. If the MCO does not wish to send contracts, please provide a detailed list of such contracts, the total costs and the amount included in the administrative cost projections (Schedule 2) for the contract period. This should include, but is not limited to:
 - Management services agreement
 - Provider contract changes effecting cost and utilization within the past year
 - Delegated CM/DM agreements
 - Delegated member/provider services agreements
 - Claims processing agreements
 - Integrated delivery system agreements
 - Agreements for the administration of vision, transportation claims and/or benefits
 - Any other contract with a related or affiliated party for non-medical services or charges
9. Start-Up Costs – The Department recognizes that additional administrative costs exist when an MCO enters into an agreement with a managed care program such as Charter Oak. Identifying each MCO's one-time, non-recurring start-up costs separately from other administrative expenses will allow the Department to review, and if appropriate, address this issue during the bid review process. Any administrative expenses identified in this section must be reasonable and

quantifiable. Please provide the following information as it relates to the administration of the Charter Oak program.

- A list of non-recurring equipment acquisitions or conversions, included in the administrative cost projections for FY2009
- A list of any planned system conversions, upgrades or initiatives for FY2009, FY2010 or FY2011 and the budgeted cost impact to Charter Oak
- Any other applicable information that will help us to understand the equipment and system changes needed to operate the Charter Oak program
- Other start-up and acquisition costs and the amount included in the administrative cost projections for FY2009
- The amortization schedule for each component of the expected start-up costs

10. Underwriting Gain and Risk/Contingency Margin – Provide justification for the requested underwriting gain and risk/contingency margin.

11. Source of Age/Sex Factors – Provide supporting documentation and justification for the factors used to adjust the community rate for individuals with incomes above 300% FPL by age and sex per the age/sex cells provided.

12. Source of Family Factor – Provide supporting documentation and justification for the factor used to adjust the community rate for individuals with incomes above 300% FPL to be applicable to families.

13. Source of FPL Factors – Provide supporting documentation and justification for the factor used to vary the community rate for those individuals and families with incomes under 300% FPL:

- 0 – 150% FPL
- 151 – 185% FPL
- 186 – 235% FPL
- 236% – 300% FPL

14. Other Assumptions – Any other assumptions or information used to prepare the projections.

Attachment 3 – Category of Service Descriptions

Service Category Descriptions

Categories of service are assigned based on a hierarchy.

Notes about the category of service:

1. The COS is assigned to the entire claim.
2. Physician-related charges are included in inpatient hospital, outpatient hospital, or emergency room COS.
3. The COS were assigned based on a hierarchy, the hierarchy is represented by the order of the table below.
4. Behavioral health, pharmacy and dental services are excluded for HUSKY.

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
1. Physical Health – Inpatient Hospital	Inpatient hospital costs including professional and ancillary services for enrollees while confined to an acute care hospital	<p><u>Revenue Codes:</u> Any claim with at least one line that contains a room and board revenue code Between 0100 and 0219</p> <p><u>Procedure Codes (Professional Services):</u> 99217-99223 99231-99236 99238-99239 99251-99255 99291-99296 99298-99300 99304-99310 99315-99316 99318 99356-99359 99431-99440 99360</p>	<p>Utilization Number of inpatient days per 1,000 members.</p> <p>Unit Cost The average cost per day</p> <p>Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from inpatient to outpatient settings</p>

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
2. Emergency Room	Includes the facility component and the professional component of the emergency room visit. The visit can be free standing or a hospital outpatient department. Professional components that are billed separately are to be included	<p>Any claim not previously categorized</p> <p><u>Revenue Codes:</u> Any claim that has not been categorized as an Inpatient stay and includes revenue codes: Between 0450 – 0452 0456 0459</p> <p><u>Procedure Codes:</u> G0380 through G0384 S9088 S9083</p> <p><u>Procedure Codes (Professional Services):</u> 99281-99288</p>	<p>Utilization Number of emergency room visits in a hospital setting per 1,000 members.</p> <p>Unit Cost Average cost per visit</p> <p>Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from emergency room to outpatient and physician service settings</p>

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
3. Physician – Primary Care	Includes the costs associated with medical services provided in a community setting (office, clinic, FQHC) by a primary care provider, including physicians and other practitioners. Includes the following providers: Internal Medicine, Family Practice, General Practice, and Pediatricians	<p><u>Any claim not previously categorized as Inpatient or Emergency Room. For the following providers:</u> Internal Medicine, Family Practice, General Practice and Pediatricians</p> <p>AND</p> <p><u>Procedure Codes:</u> Any claim containing at least one claim line with procedure codes between 90801-90815 99201-99215 99241-99245 99324-99328 99334-99337 99339-99340 99341-99345 99347-99350 99354-99355 99358-99359 99363-99364 99366-99368 99374-99380 99381-99387 99391-99397 99401-99404-99411-99412 99420-99429 99441-99443 99444 99450-99456 99477-99499 G0245 G0246-G0247</p>	<p>Utilization Number of clinic, practioner and physician visits per 1,000 members</p> <p>Unit Cost Average cost per visit</p> <p>Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from specialty physicians and outpatient hospital and emergency room or other service settings</p>

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
4. Physician – Specialty Care	Includes all costs associated with medical services provided in a community setting (office, clinic, FQHC) by a physician or other practitioner other than a PCP as identified under #3 above. Excludes the following providers (identified under #3 Physician – Primary Care): Internal Medicine, Family Practice, General Practice, and Pediatricians	<p><u>Any claim not previously categorized as Inpatient, Emergency Room or Primary Care Physician. For all other providers not identified under PCP: NOT (Internal Medicine, Family Practice, General Practice & Pediatricians)</u></p> <p>AND</p> <p><u>Procedure Codes:</u> Any claim containing at least one claim line with procedure codes between 90801-90815 99201-99215 99241-99245 99324-99328 99334-99337 99339-99340 99341-99345 99347-99350 99354-99355 99358-99359 99363-99364 99366-99368 99374-99380 99381-99387 99391-99397 99401-99404-99411-99412 99420-99429 99441-99443 99444 99450-99456 99477-99499 G0245 G0246-G0247</p>	<p>Utilization Number of physician (other than a PCP) visits per 1,000 members</p> <p>Unit Cost Average cost per visit</p> <p>Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from outpatient hospital and emergency room or other service settings</p>

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
5. Physical Health – Outpatient Hospital Non-Emergent	Includes the facility component and the professional component of the outpatient visit. The visit can be free standing or a hospital outpatient department. Any corresponding professional component that is billed separately is also reported on this service category line item	<p>Any claim not previously categorized as Inpatient, Emergency Room, or Physician</p> <p><u>Procedure Codes:</u> Any claim with a revenue code, not previously categorized as Inpatient, Emergency Room, or Physician or any claim containing at least one claim line within the following procedure code ranges: 54000-60699 90281-99602</p>	<p>Utilization Number of non-emergent outpatient hospital visits per 1,000 members</p> <p>Unit Cost Average cost per visit</p> <p>Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from inpatient to outpatient settings</p>
6. Lab/Radiology	The cost of all laboratory and radiology (diagnostic and therapeutic) services which is separately billed	<p>Any claim not previously categorized.</p> <p><u>Procedure Codes:</u> Between Q0111 and Q0115 Between P3000 and P3001 Between 70000 and 79999 Between 80000 and 89999 or Between R0070 and R0076 P7001 Q0091 36415 36416 36400</p> <p><u>Revenue Codes:</u> Between 0300 and 0314 Between 0320 and 0339 0319</p>	<p>Utilization Procedures per 1,000 eligible members</p> <p>Unit Cost Average cost per procedure</p> <p>Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from specialty physicians and outpatient hospital and emergency room or other service settings</p>

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
7. Emergency Transportation	Expenses for all ambulance services with transport to hospitals for emergency medical services	Any claim not previously categorized <u>Procedure Codes:</u> A0225 A0427 A0429 A0380 A0390 A0424 A0425 A0430 A0431 A0432 A0433 A0434 A0435 A0436 99289-99290	Utilization Number of one way trips per 1,000 eligible members Unit Cost Average cost per one way trip Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from emergency transportation to non-emergent transportation services
8. Non-Emergency Transportation	Expenses for all pre-scheduled services with transport to physician offices, medical clinics, etc. for routine non-emergent medical care	Any claim not previously categorized <u>Procedure Codes:</u> Between T2001 and T2007 A0021 A0426 A0428	Utilization Number of one way trips per 1,000 eligible members Unit Cost Average cost per one way trip Note: Adjustments from historical utilization patterns should be made for any anticipated shifts from emergency transportation to non-emergent transportation services

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
9. Durable Medical Equipment	Includes the cost of DME and supplies	Any claim not previously categorized <u>Procedure Codes:</u> Between L0000 and L4999 Between E0100 and E9999 Between A4000 and A89999 C1789 C1815 C2622 A procedure code starting with a K	Utilization Average utilization of DME equipment per 1,000 eligibles members Unit Cost Average cost of DME equipment
10. Vision	The cost of routine exams (by non-physicians) and dispensing glasses to correct eye defects. This category includes the cost of eyeglasses, but excludes ophthalmologist costs related to the treatment of disease or injury to the eye; the latter is to be included in physician specialty	Any claim not previously categorized. <u>Procedure Codes:</u> Between S0500 and S0592 Between V2020 and V2799 Between 92002 and 92499 Between 65091 and 68899 S0620 S0621	Utilization Average utilization of vision services per 1,000 eligibles members Unit Cost Average cost of vision related services

Category of Service	Description of Service	Revenue Code / Procedure Code Logic	Notes
11. Other	Any other medical service not specifically described above	Any claim not previously categorized	The anticipated utilization should be only for physical health services not described above and should be expressed as expected utilization per 1,000 members, where applicable. If “Other” services are entered, the Contractor <u>must</u> itemize these services on lines 11a through 11e and provide sufficient data to allow examination by the State (including the definition of a unit)
12. Pharmacy (Charter Oak Only)	Expenses for retail pharmacy, including the ingredient costs and dispensing fees. Carved-out. MCO not at risk	Any retail pharmacy claim with an NDC code	
13. Specialty Behavioral Health (Charter Oak Only)	Includes all inpatient claims where the primary diagnosis is behavioral health-related. For non-inpatient claims, including all claims where the primary diagnosis is behavioral health-related and one of the following factors is behavioral health-related: procedure code, provider and/or facility. MCO not at risk	See Behavioral Health Coverage grid available through the Bidders' library	

Attachment 4 – Maternity Supplemental Information Description

The delivery data will include costs associated with the prenatal period, delivery event and postpartum period. It will also provide the nature of the birth event – live, non-live, multiple, etc.

The prenatal costs should include any pregnancy-related codes found 9 months prior to the month of the delivery event (Example – If the delivery date was August 29, then the prenatal costs should be included for November (month 0) through August (month 9)). All costs should be pulled for the delivery event. The postpartum costs should include all OB costs, up to 2 months past the delivery month (Example – If the delivery date was August 29, then postpartum costs should be included for August (month 0) through October (month 2)).

Include Maternity costs associated with the following codes for still births or live births, excluding elective/induced abortions:

1. ICD9 Diagnosis: 630.x – 674.x: this will pull everything pregnancy- and delivery-related including abortions of all kinds, ectopic pregnancies, etc.
2. ICD9 VCodes: V22.x – 24.x, V27.x - V28.x.
3. ICD9 Procedure: 72.x – 75.x: these are all obstetric procedures including deliveries of all types, fetal monitoring, etc.
4. CPT : 59000 – 59899; these encompass all procedures including abortions and fetal procedures indicating pregnancy exists.
5. Revenue: 720, 721, 722, 724, 729, 0112, 0122, 0132, 0142, 0152, 0232; these include both Labor & Delivery codes as well as Room & Board with OB designation.

The Maternity grouping shall list the number of deliveries, rather than member months.

Attachment 5 – Newborn Supplemental Information Description

Include newborn claims for the partial month of birth and the first four (4) months thereafter. Age shall be determined by counting the child's age as of their last birthday, on the first of the month in which the claim is incurred.

It is expected that there shall be approximately 4.5 newborn member months reported for each delivery as the newborn time period is on average 135 days. Any variation from 4.5 member months may suggest a reporting inconsistency. For counting newborn member months, it is appropriate to group by age (in months) and then sum the first 4 months. As defined above, age should be determined by counting the child's age as of their last birthday, on the first of the month in which the claim was incurred. The following example illustrates the formula for determining a child's age in months:

Example: Date of birth = January 15

Age on January 1st – 0 months (count of 17/31 is 0 month age)

Age on February 1st – 0 months (an additional count of 1 goes into 0 month age)

Age on March 1st – 1 month (count of 1 for 1 month age)

Age on April 1st – 2 months (count of 1 placed in 2 month age)

Age on May 1st – 3 months (count of 1 placed in 3 month age)

Sum = Newborn Member Months (through example expect to have average 4.5 newborn member months per delivery)

If it is easier for the Contractor to count in whole numbers, in the 0 month age cell replace the pro-rated 17/31 with a count of 1. If this logic is utilized, the Contractor must note the counting methodology.

Schedule 1
Plan Information Worksheet

HUSKY Program and Charter Oak Program
Cost Proposal

Plan Name: [Plan Name]

Plan Address:

Address 1: [Address 1]

Address 2: [Address 2]

City, State, Zip: [City, State, Zip]

Plan CEO: [CEO name]

Proposal contact name: [Contact name]

Proposal contact title: [Contact title]

Proposal contact phone #: [Contact phone]

Proposal contact e-mail: [Contact e-mail]

Fax Number: [Contact fax]

Actuary used (if any): [Actuary name]

Actuary phone #: [Actuary phone]

Certification Statement:

We hereby affirm that the information in this premium proposal rate application including all schedules and exhibits thereto, has been prepared in accordance with the most recent instructions of the State of Connecticut Department of Social Services and to the best of our knowledge and belief is accurate and complete.

[Signature area]

Signature, Chief Executive Officer

[Date area]

Date

[Signature area]

Signature, Actuary (if used)

[Date area]

Date