DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities

Vannessa Dorantes
Commissioner

Ned Lamont
Governor

Prevention Care Management Entity (PCME) RFP

Questions and Answers

1. **Is subcontracting allowed through this contract? In one section of the RFP, it said that it was, and in another section, it indicated that it was not.**

   The use of sub-contractors is not permitted for these services.

2. **There is language on page 8 of the RFP that says the Community Pathway Populations are not eligible for intensive care coordination. It is unclear if intensive care coordination is allowable for the Community Pathways group (page 11).**

   The Contractor will provide intensive care coordination using a wraparound approach to achieve optimal outcomes for children, youth, and families through comprehensive needs assessments and the use of care management, service referral, and monitoring of the ongoing progress of families.

3. **Are the three populations, behavioral health, and voluntary populations, eligible for intensive care coordination?**

   While all three populations are eligible for care coordination, not every child will require intensive care coordination.

4. **Is a needs assessment, referral process, and not just wrap-around required for all 2650 distinct children and families?**

   Upon receipt of a referral, the CME will assess the child to determine the appropriateness of the referral, the presence of a diagnosis, and the chief complaint of the child/family to determine the best service in which to refer the child/family to treat the identified need(s).

5. **If there is more than one child in the family, does that count as two?**

   Each child should be individually assessed to determine his/her need. If there is more than one child in a family, each child should be counted individually. For continuity, the family should be assigned one care manager. When a Family First Prevention service is the recommended treatment intervention, an individualized Child Specific Prevention Services Plan must be written for each child that has been identified as a candidate for foster care in need of prevention services.

6. **On page 17, #2, there is conflicting language about startup costs. Should costs be identified as one line item or listed separately?**

   Startup cost should be listed separately as one line item in the budget section of the proposal submitted and clearly defined in the budget narrative.

7. **Are there variations in staffing allowable, like BA level for the care manager positions based on experience? Or is the licensed master's level the expectation for 47 care managers?**

   A variation of staffing will be allowable to meet the requirements of this proposal.

8. **Is some consideration being given to masters-level staff?**

   While the use of master's-level clinicians is preferable, when using a licensed bachelor's-level staff or non-licensed staff, both types of professionals must be supervised by a master's-level staff.

9. **What is the expectation for 24/7 coverage? Does this need to be a live person?**

   The Contractor is expected to provide 24/7 availability for emergency situations. The Contractor will offer flexible hours, including evening and weekend coverage, to accommodate children and families' needs, both foster and birth parents. During holidays, the Contractor is expected to clearly communicate their coverage plan to families and to the Department of Children and Families (DCF).

   There is no expectation that there be full-time staff on duty 24 hours a day. However, in an emergency, there should be some protocol as to how client needs will be addressed until the next business day.

10. **Is the ineligibility criteria applicable to all three populations?**

    Yes. However, while automatic exclusions may apply, when unique circumstances are present, the CME may institute a governance process by which the case may be reviewed for additional consideration. If an exception is granted, documentation as to the resulting conclusion must be retained. The CME is not intended to become the system's default when another entity (i.e., another state agency) has not fully served an eligible client.

11. **Can you confirm that the outcome measure of 80% of no SSR foster care involvement within 12 months is 12 months from the start of service or if it is 12 months from discharge?**

    The outcome measure is intended to be 12 months from the completion of services.

12. There is nothing in the RFP that says the work needs to be done in person.

The expectation is that the CME will do as much work in person as possible. Though the use of a hybrid model is allowable, it should not be the primary way that the CME engages families, provide case management, manage services referrals, and/or monitor the ongoing progress of a child or family. The expectation is that the CME will not implement a fully virtual program.

13. Is it the expectation that PIE will be utilized for data entry for all three populations?

Initially, a manual process of PDF referrals containing the Child Specific Prevention Services Plan will be utilized to obtain eligibility determinations from the DCF Revenue Enhancement Division. Providers of actual Family First services (i.e., Functional Family Therapy) either already, or will, utilize DCFs Program Information Exchange (PIE) for data collection and/or required reporting to DCF concerning the clients served by these programs. Also, a referral system similar to what currently exists for Emergency Mobile Psychiatric Services (EMPS), but expanded to allow for multiple referral sources (i.e., DCF, 211, CME) directing referrals to multiple Programs (i.e., FFT, MDFT), will be developed in PIE. A CME may propose development of their own data collection system that tracks referral and/or service delivery, but will need to also develop the capability of pushing required data into PIE on a regular basis through either Batch or Web Service (API) methods. Collecting all Family First data into PIE will ensure that the required Family First data are provided to the DCF Program Leads for ongoing quality assurance and continuous quality improvement efforts, as well as to the DCF Revenue Enhancement Division to perform efficient claiming activities.

14. When will we learn more about the Family First services?

Connecticut's approved Family First Prevention Services Plan that contains the prevention services selected can be found here: Connecticut's Approved Family First Plan

To review each service currently approved by the Title IVE Prevention Services Clearinghouse, please visit: https://preventionservices.acf.hhs.gov/program

15. When will services roll out and be available?

Many of the services contained in Connecticut's Family First Prevention Services plan are already offered in Connecticut. To review the status and availability of services, please see pages 36 through 43 of the approved plan.

16. Will services be available when the CME is rolled out in March?

Current services will continue to be available at the launch of the CME in March 2023. The addition of future evidence services will be evaluated in a future phase of Family First implementation (date to be determined).

17. Has work been done to determine if there is a waiting list for the seven approved EBPs in the Plan?

Specific to Family First implementation, the services contained in Connecticut's Family First Prevention Services plan have not been assessed to determine Wait List status.

18. Can the parent company of a provider organization be the applicant for this opportunity?

Yes, the parent company of a provider organization may apply for this opportunity. However, the parent company cannot refer clients to its subsidiary/provider organization to receive services.

19. Is this RFP a rebid of the contract held by Beacon Health Options?

This RFP is issued to procure services for Connecticut's new CME. While the resulting contract will include some services currently performed by Beacon Health Options, the intent is to develop a CME tasked with managing Connecticut's Prevention Services continuum, inclusive of Family First.

20. Does this RFP include any services that are currently being provided by community-based providers?

Yes. However, the RFP is designed to procure Connecticut's CME intended to engage families, provide case management, manage service referrals, and monitor the ongoing progress of families in need of eligible, prevention-based services with the primary goal of preventing such families from coming to the attention of DCF for child abuse or neglect. DCF expects that through the CME's coordination, families will receive supports from local community service organizations without the traditional involvement of DCF.

21. Please clarify the specifications for the proposal narrative. Is the line spacing double or 1.5?

The proposal format shall follow normal (1 inch) margins and 1 ½ line spacing.

22. What is the average length of a care episode?

Each evidence-based service has its own average length of care. The length of service provided shall be based on the family's level of identified need but is generally 6-9 months.

23. Are there recommendations for a treatment modality? What does this actually look like in terms of accountability?

Care coordination will likely be the most applicable approach to serving families, with many of them being referred to community providers to address their identified treatment needs.

24. What is the expected caseload per clinical team?

The expected caseload per clinical team is a minimum of 450 families annually. Each care manager will support, on average, 25-30 families at any given time. The minimum staffing model included here will be adhered to:

POSITION	FTE
Clinical Supervisor	7
Care Manager	47
Family Peer Specialist	10

25. Are you willing to readjust the timeline for submission and rollout?

To maintain the anticipated start date of March 1, 2023, the timeline for submission cannot be adjusted. Implementation is requested this fiscal year.

26. Can you partner with community agencies? For which services?

As outlined in question one above, sub-contracting is not allowed under this RFP.

27. What is the payment structure? Is it reimbursable by billable hours or grant funded up front?

The payment structure for the CME will be grant funded, upfront.

28. Are there Key Performance Indicators (KPIs) in place to establish that the program is effective?

Yes, KPIs will be established to monitor the program's effectiveness.

29. Are start-up costs included in the total funding available?

Start-up costs will be taken from the total funding available. Each anticipated cost should be clearly identified as one line item in the budget, listed separately, and clearly detailed in the budget narrative.

30. Please provide a comprehensive list of the DCF-contracted community services programs and agencies that the Care Management Entity (CME) is expected to work with.

The CME will be expected to work with all DCF-contracted providers that offer any of the prevention services supported by this RFP and/or outlined in Connecticut's approved Family First Prevention Services Plan.

31. Is it the intent that the CME establish structured data exchanges (file imports/exports) and associated data use agreements with community-based organizations, education,

health care, law enforcement, judicial/court systems, housing, behavioral health, and labor and social service systems?

Yes, the CME is encouraged to develop the required partnerships, infrastructure, and resources to ensure that relevant child-specific data is collected and shared via structured data exchange. In a future state of the CME (not covered by this RFP), exploration of the creation of cross-system data use agreements may be commenced.

32. Will there be annual budgetary provisions in the contract to account for eligible membership above 2,650 distinct children and families?

In the performance of the contract, the CME, in concert with DCFs Program Lead and Office of Grants and Contracts, will monitor contract capacity versus utilization to determine when an annual budgetary provision may be warranted.

33. How is the potential number of eligible youth/families managed by the CME determined?

Calculated utilizing historical data from referrals to existing Families First-eligible programs and utilization of the DCF-contracted Integrated Family Care and Support and Voluntary Care Management programs.

34. Will the CME receive a structured eligibility file imports for any of the three defined populations (i.e., Community Pathways, Known to DCF, or Behavioral Health Voluntary)?

The Child Specific Prevention Services Plan document for all referred clients (no matter the group) will be reviewed by the DCF Revenue Enhancement Unit (RED) for an eligibility determination. Initially the referring parties will provide this document to the RED as a PDF file, and the RED will simply reply to that communication with each eligibility determination. This process will be automated in DCF's Program Information Exchange (PIE) as part of the referral handling process, and the CME will then have electronic access to the determination documented in PIE.

35. What is the anticipated breakdown/number of families to be served in each program?

DCF does not intend for these populations to be looked at as separate and distinct, except for the purposes of provision of paid WRAP-around services for the Known to DCF and Behavioral Health populations. It is fully anticipated that there will be overlap across the populations. Clients should be assessed, have a developed Child Specific Prevention Services Plan, and be referred for direct services utilizing the same approach. The only distinction is that funding provided under the WRAP services companion contract cannot be utilized unless the child meets eligibility for the Known to DCF or Behavioral Health populations.

36. What is DCF's vision on how all concerned or interested parties will submit referrals to the CME?

DCF envisions a "no wrong door" approach. The CME will accept referrals from the child or caregiver, transferred calls from the DCF Careline, or direct referrals from other concerned or interested parties. In its simplest form, DCF envisions referrals will be made to the CME using a standardized process (i.e., a dedicated phone number).

37. Section 3(d) states that the CME should assign staff for an initial assessment within two business days of receiving referral. Section 3(e) states the initial assessment needs to be completed within two business days of receiving the referral. Please clarify the standard the CME is expected to follow.

The CME must assign all referrals to a care manager within two (2) business days from the receipt of the referral. The care manager should engage with the family to complete an initial assessment within two (2) business days of being assigned the referral. The resulting Child Specific Prevention Services Plan (completed assessment) shall not exceed seven (7) business days.

38. For members that the CME determines are eligible for services but do not fall under HUSKY Health coverage, are there screening processes or tools DCF envisioned the CME use to ensure third-party insurance is being used or is it intended to be self-reported by the member?

The RFP supports the hiring of one Eligibility Specialist. This person's role and function will be to coordinate the engagement of third-party insurance payors through the Office of the Healthcare Advocate to increase the instances that payors support the receipt of services by their clients. The intent of the Eligibility Specialist will be to maximize the utilization of all third-party billing for behavioral health claims in accordance with claims policies and procedures prior to utilization of DCF funding for any needed service.

39. The RFP states that the CME will initiate the prevention plan of care at the end of seven business days; however, the outcome measure states that 80% of families will have a prevention plan completed within seven days of referral. Please clarify when the plans of care are to be initiated and completed.

The Child Specific Prevention Services Plan should be initiated with the client no later than two (2) business days, post receipt of the client referral by the care manager. Completion of the plan should not extend beyond seven (7) business by days from receipt of the referral by the CME.

40. For data reporting to DCF's Program Information Exchange (PIE) and/or other system, please specify what data elements, file format, and layout are needed for required batch submissions.

Details specific to the data elements and file structure required by Family First can be found in the Children's Bureau, Title IV-E Prevention Program Data Elements Technical Bulletin #1. (Originally issued on August 19, 2019; reissued on October 28, 2022.) Requirements related to PIE and batch submissions will be further outlined in the final contract.

41. Section 3(e)ii states that "the remainder of the assessment protocol shall occur within seven (7) business days of receipt of referral;" however, Section C.2 in Appendix 4 states that "80% of families will have prevention plan completed within seven (7) days of a referral." Please clarify what time standard CMEs should assume (i.e., business days or calendar days.

Please apply the universal standard of business days to all timeframes.

42. Please confirm that the DCF Revenue Enhancement Unit (RED) is the responsible party for direct service payment for Community Pathways eligible members only.

The DCF Revenue Enhancement Division (RED) is not the responsible party for direct service payments for Community Pathway eligible members. RED is responsible for receiving the documentation necessary to determine a client's eligibility for Title IV-E services, in which prevention services are a subset, to support the DCFs reimbursement claim. Community Pathways eligible children will be referred by the CME to a DCF-contracted program, utilizing a slot in the program paid for by DCF. Community Pathway-only populations will not be eligible for any service requiring payment, outside of DCF's contracted service continuum, where eligible.

43. Are the 47 Care Managers listed in the table inclusive of the staff required to provide care coordination services for the Known to DCF population? If so, please confirm that DCF will allow the CME to staff the Care Manager position with a combination of master's-level, licensed staff and bachelors-level, non-licensed staff so long as the bachelors-level, non-licensed staff have the relevant background experience and are supervised by masters-level, licensed individuals.

Yes. The 47 care managers afforded under the contract are the totality of resources offered to engage care coordination services for the three distinct populations described in this RFP. Also, yes, DCF will use a combination of licensed master's-level and bachelor's-level staff and non-licensed staff to meet the program's requirements as long as all the bachelor's level and non-licensed staff have the appropriate background and experience and are fully supervised by master's-level staff.

44. For data reporting to DCF's Program Information Exchange (PIE) and/or other system, please specify what data elements, file format, and layout are needed for required batch submissions.

The required data elements, file format and layout needed for required batch submissions will be outlined in the contract.

45. The Community Pathways population is defined as "children…who do not fall under a behavioral health diagnosis;" however, Section B.1.a. states that the target population for the Community Pathways program are "children or youth 0-18 who have a substance use disorder (SUD), mental health condition, etc." Please clarify the target population for the Community Pathways program as it relates to a diagnosable SUD and/or mental health condition.

As a component of Connecticut's approved Family First Candidacy definition, children or youth ages 0-18 that have a substance use disorder (SUD) or mental health condition is one of nine community pathway populations. However, for the purposes of this RFP, those youth having a mental health diagnosis would also be able to access the services available under the behavioral health services component of the resulting contract. These services will be in addition to the approved available services under Family First. Absent a behavioral health diagnosis, community pathways youth experiencing substance use or mental health challenges will only be eligible to receive services approved through Family First.

46. How does the referral process impact third-party insurance/ turnaround times? What is the process for third-party insurers?

It will be important to partner with the Office of the Healthcare Advocate to pursue the participation of the third-party insurance payor as the primary payor. Family First should be the payor of last resort.

47. What are the specific data points DCF is expecting for the Prevention Services Plan of Care?

The specific data points that DCF is expecting to gather via the Prevention Services Plan of Care will be contained in a templated document entitled the Child Specific Prevention Services Plan. This document will be included as a reference in the executed contract.

48. What detailed information/data from the Prevention Plan of Care are CME's required to send to DCF RED and in what format will this information need to be delivered?

Using a timeframe prescribed by RED, the CME will electronically submit a PDF copy of each completed Child Specific Prevention Services plan until which time a full technology solution is developed and implemented. Specifics regarding the timing and delivery format of data will be outlined in the contract.

49. Do Community Pathways services require authorization based on clinical criteria? If yes, is it expected that re-authorization reviews will take place at regular intervals?

For Family First, services authorized under the Community Pathways require a Title IV-E Eligibility determination which is documented through an eligible service on a child's Child Specific Prevention Services Plan (CSPSP). All CSPSPs should be reviewed every six months. Community Pathway services that may be Medicaid reimbursable would be subject to the same authorization and re-authorization processes.

50. What is the role of private insurers for the authorization of community services for the Community Pathways population?

None from a managed care standpoint. However, there is an expectation that the CME, in partnership with the Office of the Healthcare Advocate, will work with a client's third-party insurance payor to ensure that all eligible costs are covered and/or authorized by the third-party payor.

51. Nearly all references to days (e.g., seven days of a referral) throughout the RFP document are written as business days. Should proposers assume that all references to day standards are business days or only when specifically written that way?

Yes, all references to day standards are business days unless otherwise specified.

52. Will DCF provide Subsequent Substantiated Report and Foster Care Entry data elements to the successful bidder in order to report on the expected outcomes?

If the outcomes remain the same post-negotiation of the finalized contract, access to the needed data elements will be provided, pending an executed Data Sharing Agreement between the DCF and the CME, and use of a Release of Information form by the CME that covers the release of outcome data back to the CME.

53. Is it DCF's intent that outcomes are tracked collectively across all three programs? If no, which outcome measures are assigned to each program?

No. The specifications for the outcome measures tracked for the three populations will be outlined in the contract specific to each program individually.