PROCUREMENT NOTICE

State of Connecticut
Department of Social Services

Medical Administrative Services Organization
Request for Proposals
CT Medical ASO RFP 06032021

The State of Connecticut, Department of Social Services (DSS or the Department), is seeking proposals from Respondents qualified to serve as an Administrative Services Organization (ASO) for Connecticut HUSKY Medical Administration Program with a primary site of operations in Connecticut, where it will administer all daily functions related to medical health services in Connecticut's HUSKY Health Program. Connecticut HUSKY Health includes both Medicaid and the Children's Health Insurance Program (CHIP).

The term of the contract shall be for three (3) years and six (6) months and is anticipated to begin on January 1, 2022 (with an inclusive six months transition phase) and continue through June 30, 2025 There shall be two (2) one-year options that may be exercised at the sole discretion of the Department.

The request for proposals (RFP) is available in electronic format on the following websites:

- CTsource Bid Board: https://portal.ct.gov/DAS/CTSource/BidBoard
- Department of Social Services: http://www.ct.gov/dss/rfp

The DSS is an Equal Opportunity/Affirmative Action Employer. Deaf and hearing-impaired persons may use a TYY by calling 1-800-671-0737. The Department reserves the right to reject any and all proposals or cancel this procurement at any time if it is deemed in the best interest of the State of Connecticut.

Questions or requests for information in must be directed to the Department's Official Contact.

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The deadline for submission of proposals is **July 23, 2021 2:00 p.m. Eastern Standard Time**.

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SECTION I – GENERAL INFORMATION

A. INTRODUCTION

1. **Name and Number.** Medical Administrative Services Organization Request for Proposals, CT Medical ASO RFP 06032021.

2. **Summary.** The Department of Social Services (DSS or Department) is seeking to contract with a qualified entity to serve as an Administrative Services Organization (ASO) to ensure that the Department's eligible Medicaid and Children's Health Insurance Program (CHIP) (collectively referred to as "HUSKY Health") members have access to medical services, and these services are coordinated with behavioral health services, and fulfill goals around the quadruple aim: improving population health outcomes, providing and administering value-based services to control costs, improving member experience, and improving provider experience. These goals should be viewed though a population health and health equity framework, which share the recognition that unmet health-related social needs, such as food and/or housing insecurity, may increase the risk of developing chronic conditions and reduce an individual's ability to manage those conditions. Specific focus areas include administrative efficiency, social determinants of health, health equity, primary, preventive, and person-centered care. To fulfill these priorities, the Department expects the entity with which it will contract to ensure recruitment and maintenance of a robust provider network; facilitate access to and appropriate utilization of high quality, covered health services; provide effective member and provider support, outreach and education; provide intensive care management for members with complex needs; deliver a robust reporting portfolio based on sophisticated data analytic systems and leadership, implement health equity-informed, system and community-driven approaches for eliminating health disparities and collaborate effectively in support of integration of services with the Department's behavioral health and dental ASOs.

   The Department expects the resultant Contractor to ensure administrative efficiency and cost-effectiveness; to be accountable to all program requirements; and to collect, analyze, report out on and use program data for continuous quality improvement, value-based care, and recommendations for improvement.

   Additionally, the Department expects the resultant Contractor to work collaboratively with other Department contractors, including, but not limited to, the Behavioral Health and Dental ASOs, and Non-Emergency Transportation broker. The integration of services in an integrated person-centered approach is critical to positive member outcomes. In addition to information sharing and care coordination, the Department expects the Contractor to jointly address and develop strategic plans to identify, investigate, and provide possible solutions to critical issues in consultation with the Department and its other contractors.

   In support of the above, the Department is requesting proposals from qualified Respondents to provide the above services. The Department is interested in innovative, forward-thinking, and dynamic proposals that manifest commitment and capacity around primary and preventive care, care delivery and payment reforms, and technology driven solutions.

The resultant Contractor shall work with and under the direction of the Department to enhance communication between various stakeholders in the HUSKY Health system, identify and address service gaps, recruit and retain both traditional and non-traditional providers, recruit out-of-state specialty providers when necessary, monitor quality of care within the provider network, and provide data-driven information related to the status of the service system and the various populations served.

The contracted ASO shall ensure high quality and timely access to community-based health services that are culturally and linguistically compatible to the members in Connecticut.

The Department seeks to achieve substantive improvements in value-based service access, appropriateness and quality of care using a population health and health equity framework. Population health has a focus on reducing the avoidable healthcare utilization and increased healthcare costs that are often the resulting reality of unmet biomedical, behavioral health, and social needs. The focus of health equity, a long-standing framework anchored in social justice, is on the equal distribution of good health with a specific emphasis on ensuring access and quality for groups that are stigmatized, marginalized, and disadvantaged as a result of historical and contemporary policies across domains that systematically affect access to opportunity. Using these frameworks, proposals should focus on preventive care, utilization management, intensive care management, appropriate emergency and disease management, as well as value-based service. Various value-based payment initiatives and other care delivery and payment reforms may result in broader changes to the duties and responsibilities of the medical ASO, such as change in scope of utilization management and quality management.

3. **Commodity Codes:** The services that the Departments wish to procure through this RFP are as follows:

   - 85000000: Healthcare Services
   - 80000000: Management and Business Professionals and Administrative Services

B. ABBREVIATIONS / ACRONYMS / DEFINITIONS

ARPA	American Rescue Plan Act
ASO	Administrative Services Organization
C.G.S.	Connecticut General Statutes
CHIP	Children's Health Insurance Program
CHRO	Commission on Human Rights and Opportunities (CT)
CMS	Centers for Medicare &Medicaid Services
CPT	Current Procedural Terminology
CT BHP	Connecticut Behavioral Health Partnership
DCF	Department of Children and Families (CT)
DMHAS	Department of Mental Health and Addiction Services (CT)
DSS	Department of Social Services (CT)
ED	Emergency Department
FOIA	Freedom of Information Act (CT)
FTP	File Transfer Protocol
HCPCS	Healthcare Common Procedure Coding System

HEDIS	Health Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
ICM	Intensive Care Management
IVR	Interactive Voice Response System
MIS	Management Information System
MMIS	Medicaid Management Information System
NCQA	National Committee for Quality Assurance
OPM	Office of Policy and Management (CT)
PCP	Primary Care Provider
POS	Purchase of Service
QM	Quality Management
RFP	Request for Proposals
SEEC	State Elections Enforcement Commission (CT)
TTY	Teletypewriter
UM	Utilization Management
U.S.	United States

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

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

Administrative Hearing: Also called Fair Hearing. An administrative proceeding conducted by an impartial hearing officer at the Department of Social Services that allows clients an opportunity to contest a decision by the Department or one of its contractors. This proceeding gives clients an opportunity to demonstrate that the Department failed to act within a required period or acted erroneously regarding coverage of or authorization of services.

Administrative Services Organization (ASO): An organization providing statewide utilization management, quality management, benefit information and intensive care management services within a centralized information system framework.

Adult: Person 18 years of age or older. However, note that, pursuant to EPSDT, certain requirements related to age are divided between individuals under age 21 and those age 21 and over.

Agent: An entity with the authority to act on behalf of DSS.

American Rescue Plan Act: This bill provides additional relief to address the continued impact of COVID-19 (i.e., coronavirus disease 2019) on the economy, public health, state and local governments, individuals, and businesses.

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

Behavioral Health Partnership ("Partnership" or "CT BHP"): An integrated behavioral health service

system developed and managed by the Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services for HUSKY Part A, B, C, and D Members, and children enrolled in the Voluntary Care Management Program funded by the Department of Children and Families.

Behavioral Health Services: Services that are necessary to diagnose, correct or diminish the adverse effects of a psychiatric and/or substance use disorder (e.g., Opioid Use Disorder, Alcohol Use Disorder).

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

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

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

Centers for Medicare & Medicaid Services (CMS): The Centers for Medicare and Medicaid Services (CMS)ion within the United States Department of Health and Human Services. CMS oversees the Medicaid program and CHIP.

Children: Individuals under eighteen (18) years of age. However, note that, pursuant to EPSDT, certain requirements related to age are divided between individuals under age 21 and those age 21 and over.

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

Children's Health Insurance Program (CHIP): Services provided in accordance with Title XXI of the federal Social Security Act, operated as HUSKY B in Connecticut.

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

Clinical Management: The process of evaluating and determining the appropriateness of the utilization of behavioral health services as well as providing assistance to clinicians or Members to ensure appropriate use of resources. It may include, but is not limited to, prior authorization, concurrent review, and retroactive medical necessity review; discharge review; retrospective utilization review; quality management; outlier management; provider certification; and provider performance enhancements.

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

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

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

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

Contract Manager: The State of Connecticut employee designated by the Departments responsible for fulfilling the administrative responsibilities associated with this contract.

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

Culturally Competent or Cultural Competence or Culturally Appropriate: A health care approach that is broadly defined as the ability of providers and organizations to understand and integrate factors such as race, ethnicity, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation into the delivery and structure of the health care system and that provides services in a manner that addresses cultural needs.

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

Critical Incident: Any incident that results in serious injury, or risk thereof, serious adverse treatment response, death of a service user, or serious impact on service delivery as defined by the Department's policies and procedures.

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

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

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

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

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

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

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

Diversity: The condition of having or being composed of differing elements, especially, the inclusion of different types of people (as people of different races or cultures) in a group or organization.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program described in and required pursuant to section 1905(r) of the Social Security Act, is a key child health component of Medicaid for all Medicaid Members under age 21. It is federally required for the Medicaid program and is designed to improve the health of Medicaid Members under age 21, by ensuring appropriate and necessary health care services. Services include periodic comprehensive health screenings, immunizations, inter-periodic encounters, vision services, dental services, hearing services, other diagnostic and treatment services, and special services. EPSDT services include case management, appointment scheduling assistance and coordination of non-emergency medical transportation, as well as making and facilitating referrals and development and coordination of a plan of services that will assist Medicaid Members under 21 years of age in gaining access to needed medical, social, educational, and other services. EPSDT services also include access to services that are not otherwise covered under the Medicaid State Plan but are optional services under section 1905(a), and which, pursuant to section 1905(r)(5) are required to be covered for an individual Medicaid Member under age 21 if it is medically necessary for that Medicaid Member and otherwise meets EPSDT requirements.

Eligible: Eligible means that the individual has been approved by the Department for membership in HUSKY Health and is entitled to services under HUSKY Health.

Eligibility Management System (ImpaCT): An automated system operated by the Department of Social Services (DSS) for maintaining eligibility information regarding HUSKY Health. It also provides fully integrated data processing support for benefit calculation and issuance, financial accounting, and management reporting.

Emergency Department (ED): A hospital emergency department (ED), also known as accident & emergency (A&E), emergency room (ER), or casualty department, is a medical treatment facility specializing in acute care of patients who present without prior appointment, either by their own means or by ambulance. The emergency department is usually found in a hospital or other primary care center or is a separate location operated by a hospital.

Evidence-Based: Referring to treatment services that have met strict scientific standards of effectiveness, and that require intensive training and supervision to ensure fidelity to the model.

Emergency or Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any body organ or part.

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

Family: Family means a child or youth with behavioral health needs and their immediate caregivers who may be comprised of biological parents, kin, foster parents, or other adults to whom legal custody or guardianship has been given and who have primary responsibility for providing continuous care to such child or youth. For adults, family refers to the individual's chosen natural support system which may include biological relatives, significant others, friends, and other supports.

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

File Transfer Protocol: The File Transfer Protocol (FTP) is a standard communication protocol for the transfer of computer files from a server to a client on a computer network.

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

Health Disparities: A particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; geographical location; or other characteristics historically linked to discrimination or exclusion.

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

Health Equity: The absence of health disparities. Health equity is achieved when every person can attain their full health potential without disadvantage because of social position or other socially determined circumstances.

Health Home (HH): As defined in Section 1945(h)(4) of the Affordable Care Act, the term "health home" means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services. Health home services include: (i) comprehensive care management; (ii) care coordination and health promotion; (iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; (iv) patient and family support (including authorized representatives);(v) referral to community and social support services, if relevant; and (vi) use of health information technology to link services, as feasible and appropriate.

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

Health Inequities: Differences in health determinants and health outcomes that are the result of social and structural imbalances and are thus avoidable and preventable.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Federal law that protects

individual's medical records and other personal health information.

Home Health Care Services: Services provided by a home health care agency (as defined in section 19a-490(d) of Connecticut General Statutes) that is licensed by the Department of Public Health, meets the requirements for participation in Medicare and meets all of the Department's enrollment requirements.

HUSKY Health: HUSKY Health is the State of Connecticut's Medicaid and Children's Health Insurance Programs, which is also known as the Connecticut Medical Assistance Program (CMAP) and includes the following broad coverage groups: HUSKY A (Medicaid coverage groups for children/parents/relative caregivers/pregnant women); HUSKY B (Children's Health Insurance Program – please note: not a Medicaid coverage group); HUSKY C (Medicaid coverage groups for the Aged/Blind/Disabled); HUSKY D (Medicaid coverage groups for Low-Income Adults, also known as the Medicaid expansion population, which was established by the Patient Protection and Affordable Care Act) and Medicaid Limited Benefit groups (including, but not limited to, as applicable, Tuberculosis Family Planning.

ImpaCT: Connecticut's Eligibility Management System.

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

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

Key Personnel: Key management personnel are employees who have the authority to directly or indirectly plan and control business operations.

Level of Care (LOC) Guidelines: Level of care is the amount of assistance/services required to meet Member needs based on medical necessity to ensure health or safety. Level of Care Guidelines are a set of objective and evidence-based behavioral health criteria used to standardize coverage determinations, promote evidence-based practices, and support Members' recovery and resiliency.

Medicaid: The program operated by the Department under Title XIX of the federal Social Security Act, and related State and Federal rules and regulations.

Medicaid Management Information System (MMIS): DSS' automated claims processing and information retrieval system certified by CMS and operated by a Contractor of DSS. It is organized into six function areas--Member, Provider, Claims, Reference, Management and Administrative Reporting subsystem (MAR) and Surveillance and Utilization Review subsystem (SUR).

Medical Assistance: For the purposes of this RFP, Medical Assistance will mean all the healthcare and related programs administered by the Department of Social Services.

Medically Necessary or Medical Necessity: As defined in **section 17b-259b of the Connecticut General Statutes:** (a) For purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted

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

(b) Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity.

(c) Upon denial of a request for authorization of services based on medical necessity, the individual shall be notified that, upon request, the Department of Social Services shall provide a copy of the specific guideline or criteria, or portion thereof, other than the medical necessity definition provided in subsection (a) of this section, that was considered by the department or an entity acting on behalf of the department in making the determination of medical necessity.

(d) The Department of Social Services shall amend or repeal any definitions in the regulations of Connecticut state agencies that are inconsistent with the definition of medical necessity provided in subsection (a) of this section, including the definitions of medical appropriateness and medically appropriate, that are used in administering the department's medical assistance program. The commissioner shall implement policies and procedures to carry out the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal not later than twenty days after implementation. Such policies and procedures shall be valid until the time the final regulations are adopted.

Member: An individual eligible for coverage under HUSKY Health.

MIS Data Dictionary: A metadata centralized repository of information about data such as meaning, relationships to other data, origin, usage, and format.

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

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

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

Program Manager: An employee of the Contractor who supports provider network development by providing profiling analyses and results, developing continuous quality improvement plans, and

supporting providers and communities in the execution of the plans.

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

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

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

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

Person-Centered: An approach that provides the individual with needed information, education and support required to make fully informed decisions about his or her care options and, to actively participate in his or her self-care and care planning. This approach also provides support to the individual, and any representative(s) whom he or she has chosen, in working together with his or her non-medical, medical and behavioral health providers and care manager(s) to obtain necessary supports and services; and reflects care coordination under the direction of and in partnership with the individual and his/her representative(s); that is consistent with his or her personal preferences, choices and strengths; and that is implemented in the most integrated setting.

Person-Centered Medical Home (PCMH) Program: The DSS Person-Centered Medical Home Program is a HUSKY Health program that provides technical assistance and specified financial incentives for eligible primary care provider practices that meet applicable requirements for the program to demonstrate improved access, quality, and coordination of care, including a glide path to assist eligible practices in becoming PCMH practices. In general, a medical home refers to a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The provider is required to provide this coordination and is encouraged to improve practice infrastructure to qualify as a medical home.

Person-Centered Medical Home Plus (PCMH+) Program: The DSS PCMH+ program is a HUSKY Health shared savings and quality improvement program for eligible participating entities that are comprised of specified PCMH practices and may also include other specified providers, in which the participating entities must provide specified enhanced care coordination activities beyond those required for PCMH and have, as applicable, financial incentives for providing care coordination add-on activities and to improve the quality of care and contain the growth of health care expenditures for their assigned members.

Presumptive Eligibility: A method of determining temporary Medicaid eligibility for individuals under the age of nineteen (19) and pregnant women, or temporary CHIP eligibility for children. The determination

is made by organizations authorized under federal and State law and approved by the Department to make presumptive eligibility determinations. These organizations are called Qualified Entities or Qualified Providers. Individuals and pregnant women who are given presumptive eligibility become entitled to Medicaid or CHIP benefits on the date the Qualified Entity or Qualified Provider makes the determination. Certain hospitals in Connecticut may also make presumptive eligibility determinations for HUSKY A and D. Qualified entities may also grant presumptive eligibility for the Family Planning Limited Benefit Coverage Group.

Primary Care Provider (PCP): A licensed health care professional responsible for performing or directly supervising the primary care services of members, which in general refers to a licensed physician, advanced practice registered nurse or physician assistant who practices in primary care and in certain contexts, may also refer to licensed Obstetrician/Gynecologists, and Certified Nurse Midwives responsible for performing or directly supervising the primary care services of members.

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

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

Procedure Codes: A broad term to identify systematic numeric or alphanumeric designations used by healthcare providers and medical suppliers to report professional services, procedures and supplies and which are required to be used for health care billing and payment pursuant to the HIPAA administrative requirements rule, 42 C.F.R. Part 162, Subpart J, as amended from time to time. Among the procedure codes used in this document are Healthcare Common Procedure Coding System (HCPCS, which include CPT codes) and Revenue Center Codes (RCCs).

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

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

Provider Network: Provider Network means all providers enrolled in HUSKY Health.

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

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

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

Qualified Provider: A medical provider who is eligible for Medicaid payments; provides the type of services provided by outpatient hospitals, rural health clinics, or other physician directed clinics; has been determined by the Department to be capable of making presumptive eligibility determinations; and

receives funds under either the federal Public Health Service Act's Migrant Health Center or Community Health Center programs, the Maternal and Child Health Services block grant programs or Title V of the Indian Health Care Improvement Act.

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

Recovery: Is what people experience themselves as they become empowered to achieve a meaningful life and a positive sense of belonging in their community (DMHAS, 2002). It is a non-linear process of development and growth, which emerges from hope; is person-driven; occurs in many pathways; is holistic; is supported by peers and allies as well as through relationships and social networks; is culturally-based and influenced; addresses trauma; involves individual, family and community strengths and responsibility; and, is based on respect.

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

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

Respondent: A private organization, defined as a non-state entity that is either a nonprofit or a proprietary corporation or partnership that has submitted a proposal to the Department in response to this RFP.

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

Retrospective Chart Review: A review of a Provider's patient charts to ensure that the Provider's documentation is consistent with the Department's utilization management policies and procedures and that patients are receiving quality behavioral health care services.

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

Risk Stratification: A statistical process to determine detectable characteristics associated with an increased chance of experiencing undesirable outcomes.

Sanction(s): A monetary penalty imposed for the failure to meet terms and conditions of the contract.

Social Determinants of Health (SDOH): The Social Determinants of Health (SDOH) are the conditions in which people are born, grow, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces, including the physical environment, economics, social policies, resources, and politics.

Socioeconomic Status (SES): Socioeconomic status is a measure of the relative influence wielded by an individual, family, or group as a result of their income, education, and occupation.

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

Subcontractor: An individual (other than an employee of the Contractor) or business entity hired by a Contractor to provide a specific health or human service as part of a contract with the Departments as a result of this RFP.

Third Party: Any individual, entity or program that is or may be liable to pay all or part of the expenditures for Medicaid furnished under a State plan.

Title XIX: The provisions of 42 U.S.C. § 1396 et seq., including any amendments thereto, which established the Medicaid program. (See Medicaid).

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

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

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

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

Utilization Review Accreditation Commission (URAC): A Washington DC-based healthcare accrediting organization that establishes quality standards for the entire healthcare industry.

Utilization Management (UM): The prospective, retrospective or concurrent assessment of the medical necessity for the purpose of authorization of care to an individual within the State of Connecticut. UM is the evaluation of the appropriateness and medical need of health care services procedures and facilities according to evidence-based criteria or guidelines.

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

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

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

C. INSTRUCTIONS

1. **Official Contact.** The Department has designated the individual below as the Official Contact for purposes of this RFP. The Official Contact is the **only authorized contact** for this procurement and, as such, handles all related communications on behalf of the Department. Respondents, prospective respondents, and other interested parties are advised that any communication with any other Department employee(s) (including appointed officials) or personnel under contract to the Department about this RFP is strictly prohibited. Respondents or prospective respondents who violate this instruction may risk disqualification from further consideration.

Name:	Vidya Ganesan
Address:	State of Connecticut, Department of Social Services 55 Farmington Avenue, Hartford, CT 06105
E-Mail:	DSS.Procurement@ct.gov

   Please ensure that e-mail screening software (if used) recognizes and accepts e-mails from the Official Contact.

2. **RFP Information.** The RFP, addenda to the RFP, and other information associated with this procurement are available in electronic format from the Official Contact or from the Internet at the following locations:

   - CTsource Bid Board: https://portal.ct.gov/DAS/CTSource/BidBoard
   - Department of Social Services: http://www.ct.gov/dss/rfp

   Registering with State Contracting Portal. It is strongly recommended that Respondents register with the State of CT contracting portal at https://portal.ct.gov/DAS/CTSource/Registration if not already registered.

   It is strongly recommended that any respondent or prospective respondent interested in this procurement check the CTsource Bid Board for any solicitation changes. Interested respondents may receive additional e-mails from CTsource announcing addendums that are posted on the portal. This service is provided as a courtesy to assist in monitoring activities associated with State procurements, including this RFP.

3. **Contract.** The offer of the right to negotiate a contract pursuant to this RFP is dependent upon the availability of funding to the Department.

   Number of Contracts: One (1) (can include subcontractors)

   The term of the contract shall be for three (3) years and six (6) months and is anticipated to begin on January 1, 2022 (with an inclusive six months transition phase) and continue through June 30, 2025 There shall be two (2) one-year options that may be exercised at the sole discretion of the Department.

4. **Eligibility.** Private organizations, defined as non-state entities that are either nonprofit, proprietary corporations, or partnerships that have a Connecticut location or a proposed Connecticut location for its business operations established within three (3) months of the resulting contract and is within a twenty (20) mile radius to downtown Hartford, Connecticut are eligible to submit proposals in response to this RFP. Individuals who are not a duly formed business entity are ineligible to participate in this procurement.

5. **Minimum Qualifications of Respondents.** To be considered for the right to negotiate a contract, a respondent must have:

   - A minimum of three (3) consecutive years of experience managing an array of medical services covered by Medicaid, serving a minimum combined total of 100,000 Medicaid members in one or more U.S. states or territories.

   - Be accredited by a nationally recognized agency such as National Committee for Quality Assurance (NCQA) and/or Utilization Review Accreditation Commission (URAC).

   The Department reserves the right to reject the submission of any respondent in default of any current or prior contract.

6. **Procurement Schedule.** See below. Dates after the due date for proposals ("Proposals Due") are target dates only (*). The Department may amend the schedule, as needed. Any change will be made by means of an addendum to this RFP and will be posted on the State Contracting Portal and the Departments' RFP Web Page.

RFP Released:	June 3, 2021
Deadline for Questions:	June 15, 2021
Answers Released (tentative):	June 25, 2021
Proposals Due:	July 23, 2021
(*) Award Decision:	September 24, 2021
(*) Start-up Transition Phase:	January 1, 2022
(*) Full Implementation of Contract:	July 1, 2022

7. **Inquiry Procedures.** All questions regarding this RFP or the Department's procurement process must be directed, in writing, to the Official Contact before the deadline specified in the Procurement Schedule. The early submission of questions is encouraged. Questions will not be accepted or answered verbally – neither in person nor over the telephone. All questions received before the deadline will be answered. However, the Department will not answer questions when the source is unknown (i.e., nuisance or anonymous questions). Questions deemed unrelated to the RFP or the procurement process will not be answered. At its discretion, the Department may or may not respond to questions received after the deadline. The Department may combine similar questions and give only one answer. All questions and answers will be compiled into a written addendum to this RFP. If any answer to any question constitutes a material change to the RFP, the question and answer will be placed at the beginning of the addendum and duly noted as such. The agencies will release the answers to questions on the date established in the Procurement Schedule. The Department will publish any and all amendments and addenda to this RFP on the State Contracting Portal and on the Department's RFP Web Page. **Proposals must include a signed Addendum Acknowledgement, which will be placed at the end of any and all addenda to this RFP.**

8. **Proposal Due-Date and Time.**

   The Official Contact is the only authorized recipient of proposals submitted in response to this RFP. Proposals **must** be received by the Official Contact on or before the due date and time

   - **Due Date:** July 23, 2021
   - **Time:** 2:00 p.m. Eastern Standard Time

   The submission of the electronic copy of the proposal must be emailed to the Official Agency Contact for this RFP to **DSS.Procurement@ct.gov**.

The subject line of the email must read: **CT Medical ASO RFP 06032021**

Proposals received after the due date and time will be ineligible and will not be evaluated. The Department will send an official letter alerting late respondents of ineligibility.

THIS IS AN ELECTRONIC SUBMISSION. Please be aware of the amount of time it may take for an electronic submission to be sent from one server and accepted by another server. Each file sent to the Official Contact, shall not be larger than 35 MB per e-mail.

The electronic copies of the proposal shall be compatible with Microsoft Office Word except for the Budget and Budget Justification, which may be compatible with Microsoft Office Excel. Only the required Forms identified in Section IV.B may be submitted in Portable Document Format (PDF) or similar file format.

The proposal **must** carry original signatures. Unsigned proposals will not be evaluated. The proposal **must** be complete, properly formatted and outlined, and ready for evaluation by the Evaluation Team.

9. **Multiple Proposals.** The submission of multiple proposals is not an option with this procurement.

10. **Claim of Exemption from Disclosure.** Respondents are advised that all materials associated with this request, procurement or contract are subject to the terms of the Freedom of Information Act, Conn. Gen. Stat. §§ 1-200 et seq. (FOIA). Although there are exemptions in the FOIA, they are permissive and not required. If a Respondent believes that certain information or documents or portions of documents required by this request, procurement, or contract is exempt from disclosure under the FOIA, the Respondent must mark such information or documents or portions of documents as EXEMPT. In Section IV. Claim of Exemption from Disclosure of its submission, the Respondent must indicate the documents or pages where the information labeled EXEMPT is located in the proposal.

    For information or documents so referenced, the Respondent must provide a detailed explanation of the basis for the claim of exemption. Specifically, the Respondent must cite to the FOIA exemption that it is asserting as the basis for claim that the marked material is exempt. In addition, the Respondent must apply the language of the statutory exemption to the information or documents or portions of documents that the Respondent is seeking to protect from disclosure. For example, if a Respondent marks a document as a trade secret, the Respondent must parse the definition in Section 1-210(b)(5)(A) and show how all of the factors are met. Notwithstanding this requirement, DSS shall ultimately decide whether such information or documents are exempt from disclosure under the FOIA.

11. **Conflict of Interest - Disclosure Statement.** Respondents must include a disclosure statement concerning any current business relationships (within the past three (3) years) that pose a conflict of interest, as defined by C.G.S. § 1-85. A conflict of interest exists when a relationship exists between the Respondent and a public official (including an elected official) or State employee that may interfere with fair competition or may be adverse to the interests of the State. The existence of a conflict of interest is not, in and of itself, evidence of wrongdoing. A conflict of interest may, however, become a legal matter if a Respondent tries to influence, or

succeeds in influencing, the outcome of an official decision for their personal or corporate benefit. The Department will determine whether any disclosed conflict of interest poses a substantial advantage to the Respondent over the competition, decreases the overall competitiveness of this procurement, or is not in the best interests of the State. **In the absence of any conflict of interest, a Respondent must affirm such in the disclosure statement*: "[name of Respondent] has no current business relationship (within the past three (3) years) that poses a conflict of interest, as defined by C.G.S. § 1-85."***

D. PROPOSAL FORMAT

1. **Required Outline.** All proposals must follow the required outline presented in Section IV of the RFP. Proposals that fail to follow the required outline will be deemed non-responsive and not evaluated.

2. **Cover Sheet.** The Cover Sheet is Page 1 of the proposal. Respondents must complete and use the form in the attached link: Cover-Sheet.

3. **Table of Contents.** All proposals must include a Table of Contents that conforms to the required proposal outline. (See Section IV.)

4. **Executive Summary.** The executive summary should provide a summarization of the services being offered to meet the Department's needs, the Respondent's approach to providing the services, and why this approach is in the best interest of the Department and Medicaid members. Respondents should also summarize their experience and qualifications as it relates to Medical Administration implementation, maintenance, and quality improvement. The executive summary should not exceed one page.

5. **Attachments.** Attachments other than the required Forms identified in the RFP, are not permitted and will not be evaluated. Further, the required Forms must not be altered or used to extend, enhance, or replace any component required by this RFP. Failure to abide by these instructions will result in disqualification.

6. **Style Requirements.** **THIS IS AN ELECTRONIC SUBMISSION.** Submitted proposals **must** conform to the following specifications:

   Paper Size: 8½" x 11", "portrait" orientation. Optionally key graphics, diagrams and flow charts can use 11" x 17" in "landscape" orientation.
   Print Style: 1 side
   Font Size: Minimum of 11-point
   Font Type: Arial or Tahoma
   Margins: The margin of all pages shall be a minimum of one and one half inches (1½"); all other margins shall be one inch (1")
   Line Spacing: Single-spaced

7. **Pagination.** The Respondent's name **must** be displayed in the header of each page. All pages, from the Cover Sheet through the required Forms, must be numbered consecutively in the footer.

E. EVALUATION OF PROPOSALS

1. **Evaluation Process.** It is the intent of the Department to conduct a comprehensive, fair, and impartial evaluation of proposals received in response to this RFP. When evaluating proposals,

offering the right to negotiate a contract, and negotiating with successful Respondents, the Department will conform to its written procedures for POS procurements (pursuant to C.G.S. § 4-217) and the State's Code of Ethics (pursuant to C.G.S. §§ 1-84 and 1-85).

2. **Evaluation Team.** The Department will designate an Evaluation Team to evaluate proposals submitted in response to this RFP. The contents of all submitted proposals, including any confidential information, will be shared with the Evaluation Team. Only proposals found to be responsive (that is, complying with all instructions and requirements described herein) will be reviewed, rated, and scored. Proposals that fail to comply with all instructions will be rejected without further consideration. Attempts by any Respondent (or representative of any Respondent) to contact or influence any Member of the Evaluation Team may result in disqualification of the Respondent.

3. **Minimum Submission Requirements.** All proposals must comply with the requirements specified in this RFP. To be eligible for evaluation, proposals must (1) be received on or before the due date and time; (2) meet the Proposal Format requirements; (3) follow the required Proposal Outline; and (4) be complete. Proposals that fail to follow instructions or satisfy these minimum submission requirements will not be reviewed further. The Department will reject any proposal that deviates significantly from the requirements of this RFP.

4. **Evaluation Criteria (and Weights).** Proposals meeting the Minimum Submission Requirements will be evaluated according to the established criteria. The criteria are the objective standards that the Evaluation Team will use to evaluate the technical merits of the proposals. Only the criteria listed below will be used to evaluate proposals.

   TECHNICAL PROPOSAL
   - A. Scope of Work Approach
   - B. Contract Management and Administration
   - C. Eligibility
   - D. Utilization Management
   - E. Notices of Action, Appeals and Administrative Hearings
   - F. Intensive Care Management
   - G. Primary Care Provider Attribution
   - H. Person-Centered Medical Home, Person-Centered Medical Home Plus and Other Care Coordination and Integration of Care Initiatives
   - I. Early and Periodic, Screening, Diagnostic, And Treatment (EPSDT) Services
   - J. Requirements for other programs and populations
   - K. Prenatal Care
   - L. Coordination of Physical and Behavioral Health Care
   - M. Coordination with Dental ASO
   - N. Coordination with Home and Community-Based Waiver Programs
   - O. Quality Management
   - P. Provider Relations
   - Q. Provider Network Development
   - R. Member Services
   - S. Telephone Call Management
   - T. Data and Reporting Requirements
   - U. Information System
   - V. Health Equity

   COST PROPOSAL
   - A. Financial Requirements
   - B. Budget Requirements

The criteria are weighted according to their relative importance. The weights of all requirements are confidential.

5. **Respondent Selection.** Upon completing its evaluation of proposals, the Evaluation Team will submit the rankings of all proposals to the Department head. The final selection of a successful Respondent is at the discretion of the Department head. Any Respondent selected will be so notified and offered an opportunity to negotiate a contract with the Department. Such negotiations may, but will not automatically, result in a contract. Pursuant to Governor M. Jodi Rell's Executive Order No. 3, any resulting contract will be posted on the State Contracting Portal. All unsuccessful Respondents will be notified by email or U.S. mail, at the Department's discretion, about the outcome of the evaluation and Respondent selection process.

6. **Debriefing**. Within ten (10) days of notification from the DSS, any Respondent may contact the Official Contact and request a Debriefing of the procurement process and its proposal. If Respondents still have questions after receiving this information, they may contact the Official Contact and request a meeting with the DSS to discuss the procurement process. The Department shall schedule and conduct Debriefing meetings that have been properly requested, within fifteen (15) days of the Department's receipt of a request. The Debriefing meeting must not include or allow any comparisons of any proposals with other proposals, nor should the identity of the evaluators be released. The Debriefing process shall not be used to change, alter, or modify the outcome of a competitive procurement.

7. **Appeal Process.** Any time after the submission due date, but **not later than thirty (30) days** after the Department notifies Respondents about the outcome of a competitive procurement, Respondents may submit an Appeal to the Department. The e-mail sent date or the postmark date on the notification envelope will be considered "day one" of the thirty (30) days. Respondents may appeal any aspect of the Department's competitive procurement; however, such Appeal must be in writing and must set forth facts or evidence in sufficient and convincing detail for the Department to determine whether during any aspect of the competitive procurement there was a failure to comply with the State's statutes, regulations, or standards concerning competitive procurement or the provisions of the RFP. Any such Appeal must be submitted to the Department Head with a copy to the Official Contact. The Respondent must include the basis for the Appeal and the remedy requested. The filing of an Appeal shall not be deemed sufficient reason for the Department to delay, suspend, cancel, or terminate the procurement process or execution of a contract.

8. **Contest of Solicitation or Contract Offer.** Pursuant to Section 4e-36 of the Connecticut General Statutes, "Any bidder or respondent on a state contract may contest the solicitation or award of a contract to a subcommittee of the State Contracting Standards Board." More detailed information is available on the State Contracting Standards Board web site at http://www.ct.gov/scsb/site/default.asp.

9. **Contract Execution.** Any contract developed and executed as a result of this RFP is subject to the Department's contracting procedures, which may include approval by the Office of the Attorney General.

SECTION II – MANDATORY PROVISIONS

A. STANDARD CONTRACT, PARTS I AND II

By submitting a proposal in response to this RFP, the Respondent implicitly agrees to comply with the provisions of Parts I and II of the State's "standard contract":

Part I of the standard contract is maintained by the Department and will include the scope of services, contract performance, quality assurance, reports, and terms of payment, budget, and other program-specific provisions of any resulting contract. A sample of Part I is available from the DSS's Official Contact upon request.

Part II of the standard contract is maintained by OPM and includes the mandatory terms and conditions of the contract. Part II is available on OPM's website at: OPM: POS Standard Contract Part II.

Note:
Included in Part II of the standard contract is the State Elections Enforcement Commission's notice (pursuant to C.G.S. § 9-612(g)(2)) advising executive branch State contractors and prospective State contractors of the ban on campaign contributions and solicitations. If a Respondent is offered an opportunity to negotiate a contract with the Department and the resulting contract has an anticipated value in a calendar year of $50,000 or more, or a combination or series of such agreements or contracts has an anticipated value of $100,000 or more, the Respondent must inform the Respondent's principals of the contents of the SEEC notice.

Part I of the standard contract may be amended by means of a written instrument signed by the Department, the selected Respondent (Contractor), and, if required, the Attorney General's Office. Part II of the standard contract may be amended only in consultation with, and with the approval of, the Office of Policy and Management and the Attorney General's Office.

B. ASSURANCES

By submitting a proposal in response to this RFP, a Respondent implicitly gives the following assurances:

1. **Collusion.** The Respondent represents and warrants that the Respondent did not participate in any part of the RFP development process and had no knowledge of the specific contents of the RFP prior to its issuance. The Respondent further represents and warrants that no agent, representative, or employee of the State participated directly in the preparation of the Respondent's proposal. The Respondent also represents and warrants that the submitted proposal is in all respects fair and is made without collusion or fraud.

2. **State Officials and Employees.** The Respondent certifies that no elected or appointed official or employee of the State has or will benefit financially or materially from any contract resulting from this RFP. The Department may terminate a resulting contract if it is determined that gratuities of any kind were either offered or received by any of the aforementioned officials or employees from the Respondent, Contractor, or its agents or employees.

3. **Competitors.** The Respondent assures that the submitted proposal is not made in connection with any competing organization or competitor submitting a separate proposal in response to this RFP. No attempt has been made, or will be made, by the Respondent to induce any other organization or competitor to submit, or not submit, a proposal for the purpose of restricting competition. The Respondent further assures that the proposed costs have been arrived at independently, without consultation, communication, or agreement with any other organization or competitor for the purpose of restricting competition. Nor has the Respondent knowingly disclosed the proposed costs on a prior basis, either directly or indirectly, to any other organization or competitor.

4. **Validity of Proposal.** The Respondent certifies that the proposal represents a valid and binding offer to provide services in accordance with the terms and provisions described in this RFP and any amendments or attachments hereto. The proposal shall remain valid for a period of 180 days after the submission due date and may be extended beyond that time by mutual agreement. At its sole discretion, the Department may include the proposal, by reference or otherwise, into any contract with the successful Respondent.

5. **Press Releases.** The Respondent agrees to obtain prior written consent and approval of the Department for press releases that relate in any manner to this RFP or any resultant contract.

C. TERMS AND CONDITIONS

By submitting a proposal in response to this RFP, a Respondent implicitly agrees to comply with the following terms and conditions:

1. **Equal Opportunity and Affirmative Action.** The State is an Equal Opportunity and Affirmative Action employer and does not discriminate in its hiring, employment, or business practices. The State is committed to complying with the Americans with Disabilities Act of 1990 (ADA) and does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services, or activities.

2. **Preparation Expenses.** Neither the State nor the Department shall assume any liability for expenses incurred by a Respondent in preparing, submitting, or clarifying any proposal submitted in response to this RFP.

3. **Exclusion of Taxes.** The Department is exempt from the payment of excise and sales taxes imposed by the federal government and the State. Respondents are liable for any other applicable taxes.

4. **Proposed Costs.** No cost submissions that are contingent upon a State action will be accepted. All proposed costs must be fixed through the entire term of the contract.

5. **Changes to Proposal.** No additions or changes to the original proposal will be allowed after submission. While changes are not permitted, the Department may request and authorize Respondents to submit written clarification of their proposals, in a manner or format prescribed by the Department, and at the Respondent's expense.

6. **Supplemental Information.** Supplemental information will not be considered after the deadline submission of proposals, unless specifically requested by the Department. The Department may ask a Respondent to give demonstrations, interviews, oral presentations or further explanations to clarify information contained in a proposal. Any

such demonstration, interview, or oral presentation will be at a time selected and in a place provided by the Department. At its sole discretion, the Department may limit the number of Respondents invited to make such a demonstration, interview, or oral presentation and may limit the number of attendees per Respondent.

7. **Presentation of Supporting Evidence.** If requested by the Department, a Respondent must be prepared to present evidence of experience, ability, data reporting capabilities, financial standing, or other information necessary to satisfactorily meet the requirements set forth or implied in this RFP. The Department may make onsite visits to an operational facility or facilities of a Respondent to evaluate further the Respondent's capability to perform the duties required by this RFP. At its discretion, the Department may also check or contact any reference provided by the Respondent.

8. **RFP Is Not An Offer.** Neither this RFP nor any subsequent discussions shall give rise to any commitment on the part of the State or the Department or confer any rights on any Respondent unless and until a contract is fully executed by the necessary parties. The contract document will represent the entire agreement between the Respondent and the Department and will supersede all prior negotiations, representations or agreements, alleged or made, between the parties. The State shall assume no liability for costs incurred by the Respondent or for payment of services under the terms of the contract until the successful Respondent is notified that the contract has been accepted and approved by the Department and, if required, by the Attorney General's Office.

D. RIGHTS RESERVED TO THE STATE

By submitting a proposal in response to this RFP, a Respondent implicitly accepts that the following rights are reserved to the State:

1. **Timing Sequence.** The timing and sequence of events associated with this RFP shall ultimately be determined by the Department.

2. **Amending or Canceling RFP.** The Department reserves the right to amend or cancel this RFP on any date and at any time, if the Department deems it to be necessary, appropriate, or otherwise in the best interests of the State.

3. **No Acceptable Proposals.** In the event that no acceptable proposals are submitted in response to this RFP, the Department may reopen the procurement process, if it is determined to be in the best interests of the State.

4. **Contract Offer and Rejection of Proposals.** The Department reserves the right to offer in part, and/or to reject any and all proposals in whole or in part, for misrepresentation or if the proposal limits or modifies any of the terms, conditions, or specifications of this RFP. The Department may waive minor technical defects, irregularities, or omissions, if in its judgment the best interests of the State will be served. The Department reserves the right to reject the proposal of any Respondent who submits a proposal after the submission date and time.

5. **Sole Property of the State.** All proposals submitted in response to this RFP are to be the sole property of the State. Any product, whether acceptable or unacceptable, developed under a contract executed as a result of this RFP shall be the sole property of the State, unless stated otherwise in this RFP or subsequent contract. The right to publish, distributes, or disseminates any and all information or reports, or part thereof, shall accrue to the State without recourse.

6. **Contract Negotiation.** The Department reserves the right to negotiate or contract for all or any portion of the services contained in this RFP. The Department further reserves the right to contract with one or more Respondent(s) for such services. After reviewing the scored criteria, the Department may seek Best and Final Offers (BFO) on cost from Respondents. The Department may set parameters on any BFOs received.

7. **Clerical Errors in Contract Offer.** The Department reserves the right to correct inaccurate contract offers resulting from its clerical errors. This may include, in extreme circumstances, revoking the offer of a contract already made to a Respondent and subsequently offering the contract to another Respondent. Such action on the part of the State shall not constitute a breach of contract on the part of the State since the contract with the initial Respondent is deemed to be void *ab initio* and of no effect as if no contract ever existed between the State and the Respondent.

8. **Key Personnel.** When the Department is the sole funder of a purchased service, the Department reserves the right to approve any additions, deletions, or changes in key personnel, with the exception of key personnel who have terminated employment. The Department also reserves the right to approve replacements for key personnel who have terminated employment. The Department further reserves the right to require the removal and replacement of any of the Respondent's key personnel who do not perform adequately, regardless of whether they were previously approved by the Department.

E. STATUTORY AND REGULATORY COMPLIANCE

By submitting a proposal in response to this RFP, the Respondent implicitly agrees to comply with all applicable State and federal laws and regulations, including, but not limited to, the following:

1. **Freedom of Information, C.G.S. § 1-210(b)** The Freedom of Information Act (FOIA) generally requires the disclosure of documents in the possession of the State upon request of any citizen, unless the content of the document falls within certain categories of exemption, as defined by C.G.S. § 1-210(b). Respondents are generally advised not to include in their proposals any confidential information. If the Respondent indicates that certain documentation, as required by this RFP, is submitted in confidence, the State will endeavor to keep said information confidential to the extent permitted by law. The State has no obligation to initiate, prosecute, or defend any legal proceeding or to seek a protective order or other similar relief to prevent disclosure of any information pursuant to a FOIA request. The Respondent has the burden of establishing the availability of any FOIA exemption in any proceeding where it is an issue. While a Respondent may claim an exemption to the State's FOIA, the final administrative authority to release or exempt any or all material so identified rests with the State. In no event shall the State or any of its employees have any liability for disclosure of documents or information in the possession of the State and which the State or its employees believe(s) to be required pursuant to the FOIA or other requirements of law.

2. **Contract Compliance, C.G.S. § 4a-60 and Regulations of CT State Agencies § 46a-68j-21 thru 43, inclusive.** Connecticut statute and regulations impose certain obligations on State agencies (as well as contractors and subcontractors doing business with the State) to ensure that State agencies do not enter into contracts with organizations or businesses that discriminate against protected class persons.

3. **Consulting Agreements, C.G.S. § 4a-81(a) and 4a-81(b).** Proposals for State contracts with a value of $50,000 or more in a calendar or fiscal year, excluding leases

and licensing agreements of any value, shall include a consulting agreement affidavit attesting to whether any consulting agreement has been entered into in connection with the proposal. As used herein "consulting agreement" means any written or oral agreement to retain the services, for a fee, of a consultant for the purposes of (A) providing counsel to a Contractor, vendor, consultant or other entity seeking to conduct, or conducting, business with the State, (B) contacting, whether in writing or orally, any executive, judicial, or administrative office of the State, including any department, institution, bureau, board, commission, authority, official or employee for the purpose of solicitation, dispute resolution, introduction, requests for information or (C) any other similar activity related to such contract. Consulting agreement does not include any agreements entered into with a consultant who is registered under the provisions of C.G.S. Chapter 10 as of the date such affidavit is submitted in accordance with the provisions of C.G.S. § 4a-81. The Consulting Agreement Affidavit (OPM Ethics Form 5) is available on OPM's website at http://www.ct.gov/opm/fin/ethics_forms
Important Note: A Respondent must complete and submit OPM Ethics Form 5 to the Department with the proposal.

4. **Limitation on Use of Appropriated Funds to Influence Certain Federal Contracting and Financial Transactions, 31 USC § 1352.** A responsive proposal shall include a Certification Regarding Lobbying Form, which is embedded in this section as a hyperlink, attesting to the fact that none of the funds appropriated by any Act may be expended by the recipient of a Federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the: (A) awarding of any Federal contract; (B) making of any Federal grant; (C) making of any Federal loan; (D) entering into of any cooperative agreement; or (E) extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

5. **Gift and Campaign Contributions, C.G.S. §§ 4-250 and 4-252(c); C.G.S. § 9-612(g)(2), and Governor Dannel P. Malloy's Executive Order 49.**
If a Respondent is offered an opportunity to negotiate a contract with an anticipated value of $50,000 or more in a calendar or fiscal year, the Respondent must fully disclose any gifts or lawful contributions made to campaigns of candidates for statewide public office or the General Assembly. Municipalities and Connecticut State agencies are exempt from this requirement. The gift and campaign contributions certification (OPM Ethics Form 1) is available on OPM's website at http://www.ct.gov/opm/fin/ethics_forms

   Important Note: The successful Respondent must complete and submit OPM Ethics Form 1 to the Department prior to contract execution.

6. **Nondiscrimination Certification, C.G.S. §§ 4a-60(a)(1) and 4a-60a(a)(1).** If a Respondent is offered an opportunity to negotiate a contract, the Respondent must provide the Department with *written representation* or *documentation* that certifies the proposer complies with the State's nondiscrimination agreements and warranties. A nondiscrimination certification is required for all State contracts – regardless of type, term, cost, or value. Municipalities and Connecticut State agencies are exempt from this requirement. The nondiscrimination certification forms are available on OPM's website at http://www.ct.gov/opm/fin/nondiscrim_forms

   Important Note: The successful Respondent must complete and submit the appropriate nondiscrimination certification form to the Department prior to contract execution.

SECTION III – SCOPE OF WORK

A. AGENCY OVERVIEW

The Department of Social Services (DSS) delivers and funds a wide range of programs and services as Connecticut's multi-faceted health and human services agency. DSS serves about 1 million residents of all ages in all 169 Connecticut cities and towns. We support the basic needs of children, families, older and other adults, including persons with disabilities. Services are delivered through 12 field offices, central administration, and online and phone access options. With service partners, DSS:

- provides federal/state food and economic aid, health care coverage, independent living and home care, social work, child support, home-heating aid, protective services for older adults, and more vital service areas.
- supports the health of over 980,000 residents[1] through HUSKY Health (Medicaid & Children's Health Insurance Program), including medical, dental, behavioral health, prescription medications, long-term services and supports.
- helps over 474,000 residents[2] afford food and supports Connecticut's economy with federally funded Supplemental Nutritional Assistance Program (SNAP).

The Department is headed by the Commissioner of Social Services and there are two Deputy Commissioners, a Deputy Commissioner for Finance and Administration and a Deputy Commissioner for Program and Operations.

Department Vision

"Guided by our shared belief in human potential, we envision a Connecticut where all have the opportunity to be healthy, secure and thriving."

Department Mission

"We, along with our partners, provide person-centered programs and services to enhance the well-being of individuals, families and communities."

B. PROGRAM OVERVIEW

B.1 Program Goals

B.1.1 Primary Goals

The Department's primary goal for this RFP is to improve the health, quality of care, and the healthcare experience of our members by focusing on the following quadruple aim through a population health and health equity framework. The medical ASO shall partner with the Department to achieve these goals.

1. Improving population health outcomes is a primary goal of the department for this RFP. This requires extensive data gathering and analysis including, but not limited to, risk assessment and risk stratification, identifying outcome disparities by race, gender, ethnicity, age, and other

[1] State Fiscal Year 2020
[2] State Fiscal Year 2020

relevant factors, identifying gaps in preventive and chronic disease care, identifying access to care gaps by mapping patient location and availability of access to healthcare services, performing social needs assessments, and behavioral health needs assessments. This data must be timely, easily accessed, easy to manipulate to allow for meaningful population level interventions and the early identification of population level trends. Based on this data, population health strategies and plans must be developed and assessed utilizing a Quality Improvement/Quality Assurance framework as part of the Quality Management (QM) plan.

2. Providing value-based services to control costs is the second primary goal of the department for this RFP. The identification of overutilization of low-value care and underutilization of high-value care is a priority to help improve population health and control costs. This requires identifying high-value care and low-value care services, identifying trends in those services, and creating actionable plans with patients and providers to impact their use.

3. Improving member experience by focusing on person-centered care at the delivery level and with their experience with the ASO is the third primary goal of the Department for this RFP. This includes assessing members satisfaction with care delivery that includes a person-centered component, members reported quality of care, and soliciting members opportunities for improvement.

4. Improving provider experience is the fourth primary goal of the department for this RFP, recognizing that a robust healthcare system is necessary to improve the health of members. This includes supporting providers achieve national accreditation and assessing provider satisfaction with Medicaid.

5. In addition to the quadruple aim, an additional goal for this RFP includes overall cost containment and increasing efficiencies.

B.1.2 Secondary Goals

Secondary goals include the continued support of person-centered medical homes and integration of services through claims level data analysis. The Department uses three Administrative Service Organizations (ASO) for medical, behavioral health, and dental services, and a broker for non-emergency medical transportation (NEMT). The Department's focus is to ensure that all members receive all appropriate and medically necessary care and it is expected that all the ASOs and the NEMT broker will work collaboratively to meet this goal. Additionally, the Department's goal is to ensure that all members receive the highest level of care by assisting providers achieve national accreditation and encouraging value-based care and outcomes.

B.2 Department Expectations And Contractor's Responsibilities and Requirements

To fulfill the goals and priorities, the Department expects the entity with which it will contract to ensure recruitment and maintenance of a robust provider network; facilitate access to and appropriate utilization of high quality, covered health services; provide effective member and provider support, outreach and education; provide intensive care management for members with complex needs; deliver a robust reporting portfolio based on sophisticated data analytic systems and leadership, implement health equity-informed, system and community-driven approaches for

eliminating health disparities and collaborate effectively in support of integration of services with the Department's behavioral health and dental ASOs.

The Department expects the resultant Contractor to ensure administrative efficiency and cost-effectiveness; to be accountable to all program requirements; and to collect, analyze, report out on and use program data for continuous quality improvement, value-based care, and recommendations for improvement.

Additionally, the Department expects the resultant Contractor to work collaboratively with other Department contractors, including, but not limited to, the Behavioral Health and Dental ASOs, and Non-Emergency Transportation broker. The integration of services in an integrated person-centered approach is critical to positive member outcomes. In addition to information sharing and care coordination, the Department expects the Contractor to jointly address and develop strategic plans to identify, investigate, and provide possible solutions to critical issues in consultation with the Department and its other contractors.

In support of the above, the Department is requesting proposals from qualified Respondents to provide the above services. The Department is interested in innovative, forward-thinking, and dynamic proposals that manifest commitment and capacity around primary and preventive care, care delivery and payment reforms, and technology driven solutions.

The resultant Contractor will work with and under the direction of the Department to enhance communication between various stakeholders in the HUSKY Health system, identify and address service gaps, recruit and retain both traditional and non-traditional providers, recruit out-of-state specialty providers when necessary, monitor quality of care within the provider network, and provide data-driven information related to the status of the service system and the various populations served.

The contracted ASO will ensure high quality and timely access to community-based health services that are culturally and linguistically compatible to the members in Connecticut.

The Department seeks to achieve substantive improvements in value-based service access, appropriateness and quality of care using a population health and health equity framework. Population health has a focus on reducing the avoidable healthcare utilization and increased healthcare costs that are often the resulting reality of unmet biomedical, behavioral health, and social needs. The focus of health equity, a long-standing framework anchored in social justice, is on the equal distribution of good health with a specific emphasis on ensuring access and quality for groups that are stigmatized, marginalized, and disadvantaged as a result of historical and contemporary policies across domains that systematically affect access to opportunity. Using these frameworks, proposals should focus on preventive care, utilization management, intensive care management, appropriate emergency and disease management, as well as value-based service. Various value-based payment initiatives and other care delivery and payment reforms may result in broader changes to the duties and responsibilities of the medical ASO, such as change in scope of utilization management and quality management.

Under the direction of the Department, the Contractor shall administer medical services in HUSKY Health for the benefit of all members, as well as specific responsibilities related to integration with behavioral health, dental, transportation, and long-term services and supports, as detailed in this RFP. This responsibility includes administration of services currently covered in HUSKY Health and all proposed and implemented additions, reforms, and modifications to HUSKY Health that occur during the contract resulting from this RFP, including any extensions.

The Contractor is responsible for ensuring that it performs the functions of the medical ASO in compliance with all applicable federal and state statutes, regulations, guidance, and other requirements that apply to these functions, including current requirements and also requirements that may be established in the future during the period of the resultant contract, including any extensions.

SECTION IV – PROPOSAL OUTLINE

INTRODUCTION

This section presents the required outline that must be followed when submitting a proposal in response to this RFP. Proposals must include a Table of Contents that exactly conforms with the required proposal outline (below). Proposals must include all the components listed below, in the order specified, using the prescribed lettering and numbering scheme. Incomplete or non-compliant proposals will not be evaluated.

In some response sections, the Department specifies a maximum number of pages for a response. The Department believes that this is a reasonable maximum number of pages and is intended to ensure that the response is focused on the requirements of this specific RFP. The stated maximum number of pages should not be used as a target or used to infer the relative importance of one section over another.

1. ADMINISTRATIVE REQUIREMENTS

The proposal must be organized as specified below:

A. Cover Sheet

See RFP Section I.D.1 for information.

B. Table of Contents

See RFP Section I.D.2 for information.

C. Claim of Exemption from Disclosure

See RFP Section I.C.10 for information.

D. Conflict of Interest - Disclosure Statement

See RFP Section I.C.11 for information.

E. Executive Summary

See RFP Section I.D.4 for information.

F. Terms and Conditions Declaration

The respondent should state that they can comply and are willing to enter into an agreement under the Terms and Conditions referenced by this RFP.

Any proposed changes to the Terms and Conditions must be specific and described here for them to be considered during contract negotiations. The State will not accept broad or open-ended statements. It should be noted that if the State determines the proposed changes to be material, it can deem a proposal to be non-compliant and therefore not evaluate it further.

G. Minimum Qualifications

The purpose of this subsection is to validate that the respondent meets the minimum criteria for a respondent as per Section I.C. 5. The respondent should list each requirement from Section I. C. 5 and attest their compliance or otherwise and then provide the Department with a way to verify the information, e.g., list projects with references, link to published records.

H. References

The Respondent shall provide a list of three specific programmatic references for the Respondent and for each proposed subcontractor, if applicable. References are preferably to be provided from within the last three (3) years of professional work that are of similar scope and focus of this RFP. References shall include the organization's name, the name of a specific contact person in the organization, a summary of the services the organization provides, the mailing address, telephone number, and email address of a specific contact person. At its discretion, the Department may also check or contact any reference provided by the respondent.

I. Forms

- Certification Regarding Lobbying
- Nondiscrimination Certification
- Gift and Campaign Contributions (OPM Ethics Form 1)
- Consulting Agreement Affidavit (OPM Ethics Form 5)
- Affirmation of Receipt of State Ethics Laws Summary (OPM Ethics Form 6)
- Iran Form (OPM Ethics Form 7)
- Notification to Bidders/Contract Compliance Monitoring Form
- Addendum Acknowledgement(s)

An addendum acknowledgement form is included with each posted addendum.

2. TECHNICAL PROPOSAL

(Technical Proposal is not to exceed 150 pages)

A. SCOPE OF WORK APPROACH

A.1 Section III. Scope of Work describes the Department's goals and expectations for this RFP.

A.1. To submit a responsive proposal, the Respondent shall:

A.1.1. Provide a summary of the approach to the above stated scope of work in Section III. Scope of Work and summarize how the proposed approach would realize the goals established by the Department.

A.1.2. Summarize the strategic business plan for the targeted deployment of administrative resources to achieve the Department's goals over the course of the three and a half-year contract. The first 6 months of such contract are designed to allow the successful Respondent to work collaboratively with the current Contractor to allow a seamless transition. This plan should be responsive to the full scope of work outlined in this RFP.

A.1.3. Put forward any suggestions that have shown to increase efficiencies and increase the effectiveness of the program. Discuss any advances in technology or program modifications which have preserved overall services and led to better patient outcomes while being mindful of financial impact.

A.1.4. Provide at least two examples where you have successfully increased efficiencies within a Medicaid program as an ASO, managed care organization, or another role as a significant Contractor to a Medicaid program.

B. CONTRACT MANAGEMENT AND ADMINISTRATION

B.1. Contract Oversight

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

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

B.1.3 PROGRAM COORDINATOR. This individual, under the direct supervision of the Contract Manager, will have day to day responsibilities of coordinating with the Contractor reporting, performance standards, performance targets (Exhibit A) (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents), regarding matters of contract compliance, contract deliverables (Exhibit B) (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents), member complaints, and provider complaints. This individual will be the primary DSS contact and intermediary for communications between DSS and the ASO to acknowledge deliverables, distribute to appropriate DSS staff for review, and communicate an approval or disapproval of the deliverable, when appropriate, on behalf of the Contract Manager. This person will attend meetings, when appropriate, at the Contractor site.

B.1.4. The Department may, at its discretion, station one or more of its employees on-site at the Contractor's place(s) of business to provide consultation, guidance and monitoring regarding the administration of the contract resulting from this RFP.

B.2. Key Person

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

B.2.2. The Contractor's key person must be approved by the Department. Such designation shall be made in writing to the Contract Administrator within five (5) working days of execution of the contract resulting from this RFP, and notification of any subsequent change of the key person shall be made in writing to the Contract Administrator for approval prior to such change.

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

B.2.4. A protocol must be defined and in place should the key person not be available and an urgent matter needs to be resolved immediately.

B.3. Key Positions and Personnel

B.3.1. Key positions shall mean executive or managerial positions. The Contractor's key positions, and key personnel must be approved by the Department. Such designations shall be made in writing to the Contract Manager at least 60 days prior to contract execution or such later date as agreed in writing by the Department. No changes, substitutions, additions or deletions, whether temporary or permanent shall be made unless approved in advance by the Department, whose approval shall not be unreasonably withheld.

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

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

B.4. Contract Administration

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

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

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

B.4.4. The Contractor shall coordinate directly with the appropriate Department representatives as directed by the Contract Manager when issues arise involving clinical care, quality of care, or safety of a member.

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

B.5. Deliverables – Submission and Acceptance Process

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

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

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

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

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

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

B.6. Committee Structure

B.6.1. The Contractor shall establish committees with family, consumer, and provider representation to provide advice and guidance to the Department and the Contractor regarding the scope of clinical and administrative services under the contract resulting from this RFP. These committees, and any other committees created, provide helpful feedback to the Contractor. This feedback shall be reviewed and incorporated into future program modifications. The Contractor shall submit a plan for the establishment or use of such committees to the Department at least 60 days prior to contract execution or such later date as approved in writing by the Department and when changes (Exhibit C) (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents) are made thereafter. Changes should be requested using the document referenced as Exhibit C.

B.7. Participation at Public Meetings

B.7.1. Under the direction of the Department, the Contractor shall ensure that the Contractor's key person (and/or other qualified Contractor personnel, as approved by the Department) attends, unless excused by the Department, all the meetings of any body established to provide legislative oversight of HUSKY Health and, upon request by the Department, also attend all other stakeholder bodies related to the administration of HUSKY Health. The Contractor shall make available appropriate Contractor Key Personnel, as directed by the Department, to attend the meetings of various bodies established to provide input into HUSKY Health, including legislative and other public committees with responsibility for monitoring the budget of the Department.

B.8. Cooperation with External Evaluations

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

B.9. Americans with Disabilities Act

Consistent with the obligations outlined in Part II, Section E.2 ("Americans with Disabilities Act") (OPM: POS Standard Contract Part II), the Contractor shall be responsible for administering the Americans with Disabilities Act ("ADA") with respect to DSS clients who are served by the Contractor. If a DSS client contacts the Department with an inquiry or request regarding an ADA accommodation for a program or service operated by the Contractor, DSS will direct the inquiry or request to the Contractor to be addressed in accordance with the Contractor's ADA policies and procedures.

Contractor shall assign an ADA administrator and provide the name and contact information of that ADA administrator to the DSS liaison named in this Contract.

Contractor shall provide a copy of all policies and procedures regarding the administration of the ADA for DSS clients to the DSS liaison named in this Contract.

Contractor shall keep records of their administration of the ADA with respect to DSS clients and provide copies of such records to DSS upon request.

B.10. Policy Manual

B.10.1. The Contractor shall produce a single integrated manual of all the policies and procedures pertaining to services provided under the contract resulting from this RFP. The manual shall include but is not limited to the specific policies and procedures provided for in subsequent sections of the contract resulting from this RFP, and which may require review and approval of the Department. The Contractor shall post the manual on a website accessible to the public and the staff of the Department. The website shall include the current version of the manual and all archived versions of the manual that contain policies in effect at any time following implementation. Certain policies and procedures may be exempt from this requirement

with the approval of the Department. The Policy Manual shall be submitted for the Department's approval by February 1, 2022 or such later date as agreed in writing by the Department.

B.11. To submit a responsive proposal, the Respondent shall:

B.11.1. Summarize initiatives that would further support this management model.

C. ELIGIBILITY

C.1. Eligibility Determination and File Production and Transmission

C.1.1. The Department shall, in accordance with the Department's individual eligibility policies, determine the initial and ongoing eligibility of each individual enrolled in HUSKY Health in accordance with the Department's eligibility policies.

C.1.2. The Contractor will be responsible for maintaining a methodology to verify member eligibility for the purpose of performing service authorization requests for members.

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

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

C.2. Eligibility Verification and Authorization Requests

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

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

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

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

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

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

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

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

C.2.2.2.1.1. Inform the provider that Medicaid is the payor of last resort. The Contractor shall require the requestor to bill other known carriers first, before billing the Department or its designated agent. This process does not apply to certain services for which Medicaid must pay first and pursue cost recovery from the other carrier ("pay and chase"). The Contractor shall follow federal regulations concerning those services.

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

C.2.2.2.2. In situations where the member is also Medicare eligible and authorization is sought for a service, the Contractor shall determine whether Medicare covers the requested services and act as follows:

C.2.2.2.2.1. If Medicare covers the service, the Contractor shall inform the provider that no authorization is necessary since it is a Medicare covered service. The Contractor shall inform the provider to (a) have the claim electronically crossed over from Medicare to Medicaid or (b) submit a claim to the MMIS vendor only after Medicare has processed the claim and to include the applicable Explanation of Medicare Benefits (EOMB) with the claim.

C.2.2.2.2.2. If the service is not a Medicare covered service, the Contractor shall follow the appropriate protocol for determining service authorizations, which is further described in the Utilization Management Section.

C.2.3. Per federal law, HUSKY B members are permitted to have coverage that is limited in scope. The Contractor shall report, in a format and timeframe to be determined by the Department when any HUSKY B member appears to have other any other health insurance.

C.2.4. The Contractor shall use the Unique Client Identification Number assigned by ImpaCT (eligibility system) to identify each eligible person. ImpaCT will assign a unique identification number for all individuals covered by the contract resulting from this RFP.

C.3. **To submit a responsive proposal, the Respondent shall**:

C.3.1. Describe its method to validate eligibility and respond to provider requests including the maximum amount of time from the time of the provider's request to the response to the provider.

D. UTILIZATION MANAGEMENT

D.1. General Provisions

D.1.1. Utilization Management (UM) is a set of Contractor processes that seeks to ensure that eligible members receive the most appropriate, least restrictive, and most cost-effective treatment to meet their identified medical needs.

D.1.2. UM, as used in this RFP, includes practices such as Registration, Prior Authorization, Concurrent Review, Retroactive Medical Necessity Review and Retrospective Utilization Review. Please describe in detail all UM strategies previously utilized and their effect.

D.1.3. UM shall serve as a source of information for providers about the availability of services and the identification of new or alternative services. The Contractor shall analyze utilization trends to perform outreach to both members and providers when necessary to ensure that members receive all the supports and services needed.

D.2. Medical Necessity

D.2.1. All decisions made by the Contractor to authorize or deny goods or services shall conform to the statutory definition of medical necessity.

D.2.2. The Contractor may use InterQual or Milliman care guidelines, other care/utilization guidelines, clinical guidelines with evidence-based criteria, or recommendations of professional societies or specialty organizations to inform authorization decisions. This also includes the development and use of internal guidelines subject to Department review and approval.

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

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

D.3.1. The Department shall review for approval the Contractor's UM Program, which shall include a program description, flow diagrams, and specific policies and procedures pertaining to

UM practices, registration, prior authorization, concurrent review, discharge review, retroactive medical necessity review, retrospective utilization review, retrospective chart review, and the bypass program.

D.3.2. The Contractor shall provide the Department, for its review and approval, the proposed UM Program by February 1, 2022 or such later date as agreed in writing by the Department. The Department shall reject, approve or approve with modifications, the proposed UM Program within 30 days of the Department's receipt of the UM Program. Once the UM Program is approved by the Department, the Contractor shall implement and follow the approved UM Program unless and until such approved program is revised with the approval of the Department. The Contractor shall revise and resubmit the UM Program to the Department for review and approval at least annually and no later than October 1st of each year.

D.3.3. Under the direction of the Department, the Contractor shall update the UM Program as needed to reflect changes in covered services, implementation of value-based payment and other payment and delivery system reforms. Such updates may include adjusting the UM Program to focus on measuring quality and financial outcomes, reducing unnecessary authorization requirements and procedures, and such other adjustments as may be necessary.

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

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

D.4.1.1. Be minimally burdensome to the provider.

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

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

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

D.4.1.5. Ensure appropriate UM is performed for all services within the scope of responsibility of the medical ASO, including services for which specific UM is required by HUSKY Health, such as services requiring prior authorization, concurrent review, or retrospective review.

D.4.2. As part of its UM Program, the Contractor shall perform the following functions related to claims billed to HUSKY Health with one or more manually priced or unlisted codes or for which HUSKY Health does not have an established payment amount or methodology:

D.4.2.1. Prepare and recommend a written methodology for the payment amount or percentage for applicable categories of such claims for approval by the Department and update such methodology from time to time, subject to the Department's approval.

D.4.2.2. Review each such claim and issue authorizations for payment amounts as appropriate based on the individual review of the claim first to determine if it is appropriate for the claim to be paid using one or more established rates or payment

methodologies or an amount similar to such established rates or methodologies, but if there is no appropriate established rate or methodology, then the Contractor will set a payment amount using the payment methodology established pursuant to subdivision D.4.2.1.

D.4.2.3. Transmit authorizations of payment amounts for each claim to the Department's MMIS Contractor. For such claims in which the code or service requires prior authorization for medical necessity or any other similar clinical utilization review, the Contractor shall perform the functions described in this paragraph as part of an integrated process that also includes performance of clinical utilization review.

D.5. Clinical Review Process

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

D.5.2. For members receiving services pursuant to an order of the court, requested services shall be authorized if they are determined to be medically necessary.

D.5.3. The Contractor shall conduct periodic reviews of authorized health services for timely and coordinated discharge planning.

D.5.4. The Contractor shall review the member's current and open authorizations when a new request for authorization is received to determine whether the requested service is a duplication of, or in conflict with, an existing service authorization.

D.5.5. The Contractor shall verify that the services to be authorized are covered under Connecticut Medicaid, and the provider to whom payment would be made is enrolled as an active HUSKY Health provider in the program from which the provider/member is seeking coverage, prior to completing an authorization for service.

D.5.6. The Contractor shall conduct retroactive medical necessity reviews resulting in a retroactive authorization or denial of service for individuals who are retroactively granted eligibility, when the effective date of eligibility spans the date of service and the service requires authorization. The provider shall be responsible for initiating this retroactive medical necessity review to enable authorization and payment for services.

D.5.7. The Contractor shall assist hospital Emergency Departments (ED) with the coordination of care, when requested by the ED. For the purposes of this request for proposal, hospital shall mean general acute care hospital including children's hospitals.

D.5.8. The Contractor shall implement a systems-based protocol for checking each service request against Intensive Care Management (ICM) thresholds that might trigger the involvement of ICM staff and shall refer to ICM staff, notifying the member of the referral, if a threshold is triggered.

D.6. Clinical Review Availability and Timelines

D.6.1. The Contractor shall provide to the Department the methods it proposes to use to identify what are currently considered to be the best evidence-based practices, and when such evidence is lacking or in conflict to support the efficacy of requested health care services, its approach to reviewing and determining whether such requests are medically necessary:

D.6.2. The Contractor shall perform appropriate utilization management for acute general hospital, general children's hospital, acute rehabilitation hospital, and chronic disease hospital inpatient services.

D.6.3. In addition to applicable utilization management, additional contacts may be necessary to facilitate timely discharge and to support transitional care coordination.

D.6.4. The Contractor shall propose information content requirements for provider requests for authorization of admission to acute care and chronic disease hospitals for the Department's approval.

D.6.5. The Contractor shall perform prior authorization reviews within the following time frames, unless federal requirements applicable to one or more of the programs included within HUSKY Health set forth more stringent requirements, in which case the federal requirements shall prevail. In the absence of such federal requirements, the following timeframes shall apply:

D.6.5.1. The Contractor shall render a decision concerning an elective hospital admission within five (5) business days; an emergency hospital inpatient admission within one business day.

D.6.5.2. The Contractor shall render decisions concerning admission to a chronic disease hospital within two business days.

D.6.5.3. The Contractor shall render a decision on requests for readmission to a chronic disease hospital from an acute care hospital within one business day. Such notice may also be communicated by telephone or electronically.

D.6.5.4. The Contractor shall authorize or deny requests for continued stay in a chronic disease hospital for clients who have exhausted third party insurance. The ASO shall render such an authorization decision within two business days from notification by the chronic disease hospital of the exhaustion of the other benefits.

D.6.5.5. The Contractor shall render a decision concerning an outpatient surgery within two (2) business days.

D.6.5.6. The Contractor shall authorize decisions concerning durable medical equipment within fourteen (14) days.

D.6.5.7. The Contractor shall authorize decisions concerning therapies (speech, physical, occupational) within one (1) business day of a new request for authorization.

D.6.5.8. For all other non-emergent services subject to a prior authorization request, the Contractor shall render a decision within fourteen (14) days of the request.

D.6.5.9. The times listed in D.6.5 shall be measured from the time the Contractor receives all information deemed reasonably necessary and sufficient to render a decision. In no event, however, shall the Contractor render a decision on a request for prior authorization more than twenty (20) days following the request.

D.7. Peer Review Requirements

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

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

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

D.7.4. The Contractor shall complete such decisions within the timeframes set forth in Subsection D.6 above. The Contractor shall offer an appointment to providers for peer review to take place within two (2) days of the completion of the first line care manager review for inpatient levels of care.

D.8. Out-of-State Providers

D.8.1. The Contractor is responsible for Utilization Management for all applicable services provided by out-of-state providers to the same extent as its responsibility for in-state providers. The Contractor shall allow an out-of-state provider who is not enrolled in the HUSKY Health Provider Network to submit an authorization request to the Contractor when required, including when an eligible member is temporarily out-of-state and requires services and in any other circumstance for which out-of-state providers are permitted in accordance with applicable federal and state requirements, including, but not limited to 42 C.F.R. § 431.52 and section 17b-262-532 of the Regulations of Connecticut State Agencies, as amended from time to time. Note that providers enrolled in HUSKY Health as border providers are treated as equivalent to in-state providers, even though they are in a different state.

D.8.2. The Contractor shall render a decision in accordance with the timeframes set forth in the timeliness standards set forth in Sections D.6.5 and D.7.3 of this RFP section. For authorization requests meeting these parameters, the Contractor shall:

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

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

D.8.2.2.1. If deemed medically necessary, provide an authorization number to the non-enrolled out-of-state provider seeking to authorize services to an eligible

member. Depending on system capabilities, this authorization may not be able to be included in the transmission of authorizations to the Department's Medicaid Management Information System (MMIS) Contractor until the provider is enrolled but it shall be transmitted within fifteen (15) business days of receipt of a provider file that indicates that the provider is enrolled.

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

D.9. Written Notice

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

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

D.10. Web-Based Automation

D.10.1. The Contractor shall establish a secure automated, web-based system to receive, screen, and respond to service registration and authorization requests for services. The web-based system must:

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

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

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

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

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

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

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

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

D.11. Staff Credentials, Training and Monitoring

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

D.11.1.1. Are individually licensed health care professionals in applicable license categories appropriate to the services performed by the Contractor, which the Department may designate or modify over time, after consultation with the Contractor, to ensure that the Contractor has the appropriate set of licensed health care professionals.

D.11.1.2. Conducting reviews shall have, at a minimum, five (5) years direct service experience in the delivery of medical services.

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

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

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

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

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

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

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

D.11.4. The Contractor shall throughout the term of the contract resulting from this RFP, retain at least one full-time Medical Director 100% of whose time is dedicated to the fulfillment of the Contractor's obligations under the contract resulting from this RFP and to the clinical supervision of all of the Contractor's clinical management functions. The Medical Director must be on-site in the Contractor's primary Connecticut location. The Contractor shall require and ensure that the Medical Director is a physician, board certified or eligible in their clinical specialty with experience in population health and the clinical treatment and management of individual members enrolled in a public sector health care program. The Contractor may split

this position between up to two part-time physicians subject to the Department's review and approval. The Contractor must demonstrate and certify to the Department that the split position retains full time equivalency and adequacy of coverage for the population.

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

D.12. Records

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

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

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

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

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

D.12.1.5. Start and stop dates of authorization period.

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

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

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

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

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

D.12.1.11. Authorization number, date, and time.

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

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

D.12.1.14. The program under which coverage is provided for each service request; which will in turn indicate whether a Notice of Action (NOA) or denial is required to be sent for adverse decision.

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

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

D.12.1.17. An indicator for individuals eligible for ICM, which would include an ICM start and end date.

D.12.1.18. Additional elements may be requested by the Department to meet MMIS requirements.

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

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

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

D.12.3.2. Clinical review notes.

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

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

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

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

D.13. Inpatient Census Report

D.13.1. The Department shall require all inpatient general and chronic disease hospitals to notify the ASO of all inpatient admissions of individuals dually eligible for Medicare and Medicaid. The ASO shall use the data for the purposes of initiating ICM when appropriate and for patient assistance in establishing a relationship with a primary care provider or specialist.

D.13.2. The Contractor shall develop and present to the Department for review and approval by January 1, 2022 or such later date as may be provided in writing and agreed to by the Department, , a process to provide the primary care provider, medical home, or health home with a daily census report as indicated in Exhibit E (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents), which shall include all individuals admitted to general hospitals and chronic disease hospitals. The Department shall accept or reject the process within 30 days of the receipt of the proposed process.

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

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

D.14. Transitional Care Management

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

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

D.14.2.1. Identification of patients who are admitted to inpatient or observation status, and upon discharge, confirming they have follow-up with an outpatient provider within 14 days. If no follow up is identified, helping to identify an appropriate follow-up plan.

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

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

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

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

D.14.2.6. Monitor to confirm patients have completed a follow up visit with their outpatient provider. If this does not occur follow-up with the patient to determine why and attempt to help reschedule. If patient does not have appropriate follow up then referral to ICM.

D.14.2.7. Transitional coordination shall ensure that necessary member education regarding the care plan has occurred post-discharge and include condition specific self-

management education. When necessary for the success of the aftercare plan, the Contractor will be expected to meet with the member to educate them about their care plan.

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

D.14.3.1. Identifying reasons for unsuccessful follow-up care and communicating this to the Contractor's Quality Management unit.

D.14.3.2. Identifying inpatients who would qualify for Intensive Care Management (using the criteria in Section E below) and referring them for enrollment in ICM.

D.14.3.3. The Contractor shall coordinate with the appropriate waiver personnel to augment any necessary medical or disease management identified as the individual transitions from a skilled nursing facility to a community setting or placement.

D. 15. Prior Authorization (PA) Transaction Batch File. The Contractor shall submit a daily Prior Authorization (PA) transaction batch file of all authorized services to the MMIS Contractor. The batch file layout will be in a format specified by the Department.

D. 15.1. The Contractor shall accept and process a Daily error file from the MMIS Contractor in response to the PA transaction file received from the Contractor.

D.15.2. The Contractor shall accept and process a 'units used' file from the MMIS Contractor, after each financial cycle, typically on a bi-monthly basis. The units used file will be allow the Contractor to retain a complete record in its care management system of units used against total units authorized.

D.15.2.1 The PA Transaction file from the Contractor and the Daily Error file and Units Used file to the Contractor from the Department's MMIS Contractor will be exchanged electronically via File Transfer Protocol (FTP) or other mutually agreeable and secure means of transmission.

D.16. To submit a responsive proposal, the Respondent shall:

D.16.1. Provide a written program description outlining the UM program model, methods, structure and accountability that would be implemented for the resultant contract.

D.16.1.1. The description shall include the Respondent's recommendation for services that will be subject to prior authorization, proposed standards to determine which individuals require transition planning (or alternatively, which do not) and strategies to enlist the provider community's cooperation with and support of its UM program.

D.16.1.2. Include a proposed organizational UM staffing chart and flow chart consistent with the program description.

D.16.2. Provide a proposal of UM system capabilities.

D.16.3. Describe the level of care guidelines that are used for utilization review.

D.16.3.1. Discuss how these guidelines are updated.

D.16.3.2. Describe any other databases or information resources that will be used to support utilization review decisions.

D.16.3.3. Describe how utilization review will be based on the latest medical evidence and allow the rigorous and appropriate application of the statutory definition of medical necessity for HUSKY Health.

D.16.4. Propose a “bypass” program to enable high performing providers to fulfill prior authorization requirements through the notification process. The Respondent shall at a minimum describe the process that would be used to identify providers who would be eligible for participation, the percentage of providers using it in their existing contracts, and the procedures for conducting random retrospective audits (data and/or on-site) to ensure continued qualification as a high performing provider. Include a methodology to monitor the success of the overall program, and the performance of those providers put on “bypass.”

D.16.5. Propose an approach to facilitating and enhancing the discharge planning process and the provision of transitional care management for individuals admitted to inpatient facilities, to include but not be limited to proactive plans of care and follow-up, strategies for communication, medication information and reconciliation, and processes for transitions or "hand-offs" (across providers and settings).

D.16.6. Propose an approach to monitor transitional care management, including tracking of hospital readmissions, and coordination of transitions of care for individuals receiving waiver services with the appropriate waiver personnel.

D.16.7. Propose how the Contractor’s utilization management program may improve efficiencies and member outcomes.

D.16.8. Identify any Transitional Care Management sub-team (e.g. Inpatient Discharge Care Management, Emergency Department Care Management) and delineate the team’s specific responsibilities.

E. **Notices of Action, Appeals and Administrative Hearings**

<u>E.1. Medicaid (HUSKY A, C, and D) General Requirements</u>

E.1.1. The requirements for the content and issuance of Notices of Action and the processes for appeals to the Contractor and, thereafter, to the Department’s Office of Legal Counsel, Regulations and Administrative Hearings are mandated by state and federal statute and regulations, and by Constitutional due process requirements.

E.1.2. To the extent that there are changes in state or federal law that affect these requirements or policies, the Contractor shall be required to modify the processes at the direction of and with the approval of the Department.

E.2. Notices of Action

E.2.1. The Contractor shall meet or exceed the notice of action and appeal process requirements as specified in this Section. The Contractor shall submit to the Department for its review and approval, a Member Appeals Process including policies and procedures related to the administration of Notices of Action, an internal appeals process and administrative hearings in accordance with this section.

E.2.2. The Contractor shall generate Notices of Action specific to each type of action. Notices shall be communicated in writing and sent out as expeditiously as possible, but no later than two (2) business days following the date of the decision on the authorization request. If the action involves a decision to terminate, suspend or reduce services the member has been receiving, the notice shall be issued at least ten (10) days in advance of the effective date of the intended action, allowing five (5) additional days for mailing.

E.2.3. The Department shall provide the Contractor with templates for the notices of action required by this section. The Contractor shall submit final standardized notices of action to the Department for review and approval, the format and content of which may not be altered without the prior written approval of the Department. The Contractor shall also include instructional sheets or information on the appeals and hearing process with the notice, as directed by the Department.

E.2.4. The Contractor shall require and advise members that the member may file a hearing request in writing within sixty (60) days of the receipt of the notice on a form provided by the Department. Hearing requests may be filed by the member; the member's authorized representative, a conservator or guardian, or the member's parent or guardian if the member is under the age of 18.

E.2.5. The Contractor shall track all appeals and hearing requests in a database. Daily reports shall be run from this database. Decisions to deny, partially deny, terminate, suspend or reduce services shall be entered into a database. All notices of action, with appropriate appeals rights, shall be generated from this database. While certain information on the notices (such as name, address and client identifiers) may be prepopulated and automated, the Contractor's process and system for issuing notices must allow for individualized content and explanations, including clinical explanation of the action being taken with respect to a specific member.

E.2.6. The Contractor shall complete a quality control check on all Notices of Action. The Quality Control Check must be performed by an individual(s) with specific training on the contractual and legal requirements for notices and processes.

E.3. Continuation of Services Pending Appeal/Hearing

E.3.1. If the Contractor terminates, suspends or reduces an existing services being provided to a Medicaid member, the member has a right to continuation of those services, provided that the member files an appeal/hearing request within ten (10) calendar days of the date the NOA is mailed to the member, or the effective date of the intended action, whichever is later.

E.4. Contractor Appeals Process – Routine and Expedited

E.4.1. The Contractor shall develop and implement a timely and organized appeal process to resolve disputes between the Contractor and members concerning the Contractor's

authorization decisions. The Contractor shall designate one primary and one back up contact person for its appeal/administrative hearing process.

E.4.2. The process for pursuing an appeal and for requesting an administrative hearing shall be unified for Medicaid members. The Contractor and the Department shall treat the filing of an appeal as a simultaneous request for an administrative hearing.

E.4.3. Hearing requests by Medicaid members shall be mailed or faxed to a single address within the Department. The Department will set and the Contractor shall adhere to specific timeframes for the communication of requests back and forth between the Department and the Contractor, for both routine and expedited appeal requests.

E.4.4. An individual(s) having final decision-making authority shall render the Contractor's appeal decision.

E.4.5. An appeal may be decided on the basis of the written documentation available unless the member requests an opportunity to meet with the individual or individuals making that determination on behalf of the Contractor and/or requests the opportunity to submit additional documentation or other written material.

E.4.6. The Contractor shall attempt to resolve the appeal and issue a written appeal decision at the earliest point possible, but no later than thirty (30) days following the filing of the appeal.

E.5. The Hearing Summary and Administrative Hearing.

E.5.1. The Contractor shall prepare the administrative hearing summary within the timeframe and according to the specifications required by the Department's policy and requirements.

E.5.2. The Contractor shall attend the administrative hearing and present and defend the action taken. The Contractor's representative at the hearing will have the clinical or other qualifications necessary to defend the merits of the action.

E.5.3. The Contractor shall abide by and implement the hearing officer's decision.

E.6. Notices and Appeals – CHIP (HUSKY B)

E.6.1 The Contractor shall also issue notices when it acts on a request for authorization of services from a provider for a HUSKY B member. The Contractor shall follow all applicable appeal procedures set forth in subsection E.4 and 5, above. If the Contractor upholds its original decision on the determination, the appeal will be reviewed by the Department's medical director, or another clinician within the Department, designated by the medical director. The medical director or his designee will issue a final decision on the Contractor's determination. The Contractor shall abide by the Department's decision.

E.7 Provider Reevaluation Process

E.7.1. General Provisions

E.7.1.1 A provider may submit to the Contractor a request for reevaluation of (A) a determination of medical necessity or (B) an administrative decision.

E.7.1.2 The Contractor shall maintain a Reevaluation Process including policies and procedures related to the administration of denials and internal processes. Any changes made to this process are subject to prior approval by the Department.

E.7.2 Reevaluation of Medical Necessity: Level One

E.7.2.1 Upon receipt of the decision of a denial or partial denial of a prior authorization request from the Contractor, a provider may initiate the reevaluation process by notifying the Contractor either electronically or in writing. The provider shall be required to initiate the reevaluation no later than ten (10) calendar days from the date of the initial determination letter from the Contractor.

E.7.2.2 The Contractor shall complete arrangements for peer review within one (1) business day upon notification of a reevaluation request, to be conducted at a mutually agreed upon time. A peer desk review will be conducted if the provider peer is unavailable or is accepting of an alternative good or service. The Contractor shall render a determination in response to the reevaluation request and notify the provider telephonically no later than one (1) business day following completion of the peer review or peer desk review. The Contractor shall mail notice of the reevaluation determination to the provider within two (2) business days.

E.7.3. Reevaluation of Medical Necessity: Level Two

E.7.3.1. If the provider is dissatisfied with the first level reevaluation determination, the provider may initiate as second level reevaluation by sending written or electronic notice to the Contractor no later than fourteen (14) calendar days after the first level reevaluation denial. The provider may submit additional supporting documentation including the medical record within thirty (30) calendar days of the request for reevaluation.

E.7.3.2. The Contractor shall send the provider notice of the determination of the second level reevaluation no later than five (5) business days after receipt of information deemed necessary and sufficient to render a determination.

E.7.4. Reevaluation of an Administrative Decision

E.7.4.1. A provider may request reconsideration of a determination by the Contractor based on non-compliance by the provider with policies and procedures pertaining to utilization management.

E.7.4.2. The provider may, no later than ten (10) calendar days from the date of the determination letter from the Contractor, initiate an administrative reevaluation request by providing the Contractor with a rebuttal with additional information or good cause.

E.7.4.3. The Contractor shall mail a notice of the determination to the provider within seven (7) business days following receipt of the reevaluation request. The notification shall include the principal reason for the determination and instructions for requesting a further reevaluation, if applicable.

E.7.5. Outcome of Reevaluation Process

E.7.5.1. If the reevaluation process is followed and the denial determination is overturned, the Contractor shall authorize services to allow for provider payment for covered services rendered to a member.

E.7.5.2. If the reevaluation process is not followed or if the reevaluation process is followed and the reevaluation is denied, the Contractor shall not authorize provider payment for the services that are the subject of reevaluation.

E.8. To submit a responsive proposal, the Respondent shall:

E.8.1. Propose how compliance with Notices of Action, Appeals and Administrative Hearings will be monitored as set forth above.

F. INTENSIVE CARE MANAGEMENT

F.1. General Provisions:

F.1.1. With the expansion of PCMH and PCMH+ community providers, services comparable to those provided in Intensive Care Management (ICM) will, as much as possible, be provided in the community setting through a member's medical home. ICM is a comprehensive program that provides multi-disciplinary approach and patient care activities for individuals with significant clinical conditions and/or complex needs that severely impact their daily lives. These members may have one or more chronic conditions with or without co-occurring behavioral health conditions, or nonclinical circumstances which prevent them from effectively utilizing medically necessary care. The role of the Contractor in ICM will be focused on:

F.1.1.1. Engaging members who are not engaged with or do not have a primary care provider and helping them reengage or establish with a primary care provider,

F.1.1.2. Assisting and monitoring PCMH practices and PCMH+ participating entities to ensure sufficient access to and high-quality provision of appropriate care coordination services that meets members' needs,

F.1.1.3. Providing ICM services to members with specific health needs as determined by the Department, and

F.1.1.4. Collaborating closely with the Department's behavioral health ASO **Contractor** in serving members with co-occurring physical and behavioral health needs.

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

F.1.2.1 Improving care coordination by enhancing the member's ability to access and participate in preventive care.

F.1.2.2 Encourage member's active participation in the prescribed plan of care.

F.1.2.3. Coordinating and organizing the care using a person-centered, holistic, multidisciplinary primary care and specialty practice team.

F.1.2.4 Identifying Social Determinants of Health (SDOH) and other barriers in health care to prevent health disparities.

F.1.2.5. Recruiting the personnel and other resources required to support the individual and to address their needs.

F.1.2.6 Ongoing in-services and training to all ICM staff regarding Cultural Sensitivity and Implicit Bias to meet the individual preferences and unique needs of the members.

F.1.2.7. Exchanging information among participants responsible for different aspects of the care, including the member and/or authorized representative.

F.1.2.8. Delineating and informing participants about each other's roles in the person's care and the available resources to fulfill the care plan.

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

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

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

F.1.5. Preventive care remains the cornerstone of all care, most especially for individuals with chronic conditions and co-morbidities. Routine preventive care is essential in promoting and maintaining the health status of all members regardless of their clinical circumstances. Prevention is a vital element of health care particularly those with chronic illnesses to prevent and minimize progression of the disease process, and to prevent further health complications. Therefore, it is crucial to reduce the incidence of preventable diseases through health promotion and preventive interventions Although the population bears a significant chronic disease burden, it does so in the context of poverty and cultural diversity, and other SDOH, which add to the challenges of caring for one's chronic disease in the face of other adversity and unmet daily needs. It is expected that the Contractor's ICM program will include staff members whose expertise include but not limited to the care of those individuals from diverse ethnic, cultural, and socioeconomic backgrounds.

F.1.6. The Medical Administrative Service Organization (ASO) is expected to oversee ICM provided at or through the ASO's primary location in Connecticut, however, regional deployment of an Intensive Care Management team in the field is necessary to build local collaborative relationships and improve effectiveness of the program.

F.1.7. As the Medical ASO and the Department recruit and certify Person-Centered Medical Home (PCMH) practices and PCMH+ participating entities and further incorporating further changes to and additional elements of HUSKY Health programs related to improving care coordination that may be modified or added in the future, the ASO will have less of a role in coordinating care for individuals attributed to PCMH practices and assigned to PCMH+ participating entities. In many cases, it is expected that the Medical ASO will identify high risk individuals and provide linkages to the PCMH / PCMH+ providers. PCMH practices that meet the special requirements for serving as a Health Home will be expected to provide all necessary care coordination services (comparable to services provided by ICM) for members attributed or assigned to them, as applicable. The Medical ASO will be expected to identify high risk members and link these members to care coordination services provided by PCMH practices, PCMH+ participating entities, and any other similar source of care coordination available from community-based providers. Although the Department envisions a migration of care coordination and ICM functions to local PCMH practices /PCMH+ participating entities and other practices, clinics and service delivery systems, there may be an ongoing role for the Medical ASO with respect to these functions. These functions will continue to be necessary for individuals who are not attributed to a PCMH/PCMH+ or other programs that do not yet provide ICM services under Medicaid reimbursement. In addition, it is possible that the Medical ASO could establish local hubs that support multiple small group practices to establish dedicated resources on site, which would be subject to the Department's direction and approval.

F.2. Intensive Care Management Program Development and Approval

F.2.1. The Contractor shall submit their proposed ICM Program including a program description, policies, procedures, workflows, and qualifying criteria for children, adolescents, and adults to the Department of Social Services for its review and approval on or before March 1, 2022 or such later date as agreed upon in writing by the Department..

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

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

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

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

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

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

F.2.8. In the first year, the **Contractor**'s ICM Program shall include the following special populations in addition to those populations identified through the Contractor's predicting modeling and health risk stratification methods:

F.2.8.1. High risk and high cost members who are not following regularly with a primary care provider or who do not have a primary care provider.

F.2.8.2. Members obtaining gender affirming surgery and treatment.

F.2.8.3. Members obtaining organ transplant.

F.3. Local Area Assignment

F.3.1. Intensive care managers shall be designated to specific geographic areas within Connecticut, allowing for cross-coverage as needed.

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

F.4. Reporting

F.4.1. The Contractor shall provide a report as described in Exhibit E https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents Reporting Matrix of members who have been identified by the Contractor for ICM to the Department.

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

F.4.2.1. Coordination and quality issues by provider and geographic area (see Exhibit E) https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents

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

F.5. To submit a responsive proposal, the Respondent shall:

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

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

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

F.5.1.3. A description of proposed data analytics for population health management and/or health risk stratification that support intensive care

management. The detailed narrative should communicate the uniqueness of the Respondent's capabilities in this area.

F.5.1.4. ICM process including identification of members requiring ICM, enrollment processes, intervention strategies for ICM, use of a care plan, coordination with primary care and other providers, and local services and supports.

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

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

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

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

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

F.5.1.10. Describe any analyses that the Respondent has undertaken using claims or encounter data to develop care management or ICM priorities.

F.5.1.10.1 Propose monthly ICM program capacity (e.g., individuals served per month).

F.5.1.10.2. Propose areas to focus ICM resources during the first two (2) years of the contract.

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

F.5.1.12. Provide an example of ICM care plans and describe the process that would be utilized to capture data related to care plans.

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

F.5.1.14. Describe the process by which the ICM unit will communicate and coordinate care with the Department's behavioral health and dental ASOs and the non-emergency medical transportation broker.

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

F.5.1.15. Describe how the - ICM resources might be modified or reduced in coordination with the emergence of PCMH/PCMH+/and other providers of integrated care and care coordination.

F.5.1.16. Provide a description of how the Respondent's proposed ICM program takes into consideration cultural diversity, domestic violence, poverty, and homelessness.

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

F.5.1.17 Describe how and the extent to which ICM will be provided for Dually eligible (Medicare and Medicaid) members. Although Medicare is the primary insurer for dually eligible members, Medicaid is responsible for deductibles and other cost shares. It is expected that the Contractor will engage with duals in promoting positive health outcomes even though Medicaid may not have a direct impact on care at the onset.

F.5.1.18 Describe approaches to providing ICM to other unique populations in need of this service and how outcomes will be measured.

G. PRIMARY CARE PROVIDER ATTRIBUTION

G.1. General Provisions

G.1.1. Primary Care is a key foundation of high quality and affordable health care and helping individuals stay healthy and prevent the occurrence or deterioration of disease and other health problems. Adequate access to primary care is associated with greater use of preventive care and in improvements in patient satisfaction, patient outcomes and health service value. Primary care access and the use of preventive or routine care by Medicaid and CHIP members is a primary goal of the Department.

G.2. Requirements of the Contractor

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

G.2.2. The Contractor shall work with the member to help locate a PCP and provide members with the opportunity to select a PCP. If the member fails to select a PCP, the Contractor shall attribute a member to a PCP within two (2) weeks from the thirtieth (30^{th}) day of enrollment as follows:

G.2.2.1. The Contractor shall review the member's office visits (if any) over the previous 15 months and shall base the attribution on the most recent or most frequent visit.

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

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

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

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

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

G.2.6. The Contractor shall allow members to change their preferred PCP at any time. The Contract that results from this RFP will not change members' access to HUSKY Health services, in which the member may see any qualified provider that is enrolled in HUSKY Health.

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

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

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

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

G.2.8.2. The Department is interested in expanding capacity of behavioral health integration within primary care. The Contractor will be expected to support and facilitate primary care practices that are interested in building behavioral health capacity within their primary care practice, in collaboration with the Department's Contractor that is the behavioral health ASO.

G.3. To submit a responsive proposal, the Respondent shall:

G.3.1. Propose a PCP Attribution plan that meets all the above requirements.

G.3.2. Propose how an increase in primary care or routine care utilization would decrease the need for acute care services. Provide utilization and cost data to support the successful shift over time from over utilization of acute care to more appropriate use of primary care or routine care.

G.3.3. Provide a description on how the Contractor would assist primary care practices who are interested in building behavioral health capacity within their primary care practices.

H. PERSON-CENTERED MEDICAL HOME, PERSON-CENTERED MEDICAL HOME PLUS AND OTHER CARE COORDINATION AND INTEGRATION OF CARE INITIATIVES

H.1. General Provisions

H.1.1. PCMH and PCMH+ embody a collective Department approach and priority to providing accessible, continuous, coordinated and comprehensive primary care that facilitates partnerships between individual members and their personal providers, and when appropriate, the member's family and other individuals chosen by the member. The focus in this person-centered approach is on the person who has various conditions, and how the conditions impact the person's life, rather than on the conditions themselves. If implemented successfully, this approach results in better informed members who are better able to participate in their care, ultimately leading to better clinical outcomes.

H.1.2. Using PCMH, PCMH+, and other similar concepts related to integrated care and improved care coordination may allow better access to health care, increase satisfaction with care, and improve health and additional details are set forth in applicable program documents for each initiative.

H.1.3. PCMH/PCMH+ providers are designated by the Department based on the requirements applicable to each initiative.

H.1.4 PCMH+ builds on the success of the PCMH program and works to improve HUSKY member's overall health and assists with access to services like access to healthy food, transportation to appointments and assistance in finding community agencies that support housing or employment.

H.2. Requirements of the Contractor.

H.2.1. The Contractor shall implement procedures to coordinate the attribution and assignment of members to PCMH and PCMH+ providers, as applicable, as directed by the Department and in accordance with the requirements for each such initiative.

H.2.2. The Contractor shall provide notifications to the Department about applicable PCMH, PCMH+ and other applicable attribution and assignment. As directed by the Department, the Contractor may also be required to provide certain notifications to the providers for one or more of the initiatives.

H.2.3. Under the direction of the Department, the Contractor shall provide ongoing recruitment of potential PCMH practices, retention of PCMH practices, and ongoing monitoring and reporting of the performance of PCMH practices, including, but not limited to, measuring access, utilization, and quality of PCMH practices and providing reports to the Department in a specified manner and frequency, and other activities as designated by the Department. As appropriate, the Contractor shall provide recommendations and analysis to the Department in evaluating the PCMH program and suggesting updates to the program to the Department.

H.2.4. Under the direction of the Department, the Contractor shall provide ongoing assistance to the Department with the administration of the PCMH+ program, including measuring access, utilization, and quality of PCMH+ participating entities; evaluation of PCMH+ participating entities' performance of required enhanced care coordination activities and integration with partner organizations in addressing social determinants of health; analytic evaluation of program savings; and other activities as designated by the Department.

H.2.5. The Contractor shall send the MMIS Contractor information on newly added PCMH practices, as well as changes to the PCMH practices in a file format specified by the Department.

H.2.6. The Contractor shall perform calculations to determine yearly PCMH incentive and improvement payments. Information provided to the Department will include the provider AVRS id and payment amount broken out by program (HUSKY A, B, C and D).

H.2.7. The Contractor shall determine HUSKY B + eligibility and provide the MMIS vendor with HUSKY B + client id, eligibility dates coverage group and program type.

H.2.8. The Contractor shall be responsible for working with the MMIS vendor to review retrospective out of state claims and determining medical necessity. The claims will be made available in the MMIS system. The outcome of the review will be recorded in the MMIS system.

H.3. To submit a responsive proposal, The Respondent shall:

H.3.1. Propose a plan to implement PCMH and PCMH+ that meets all the above requirements.

H.3.2. Describe their experience managing a PCMH or similar initiative and provide outcomes of your prior work in that PCMH or similar initiative.

H.3.3. Describe how data analysis and health care outcome reporting will be customized by PCMH and PCMH+ provider and the ability to compare PCMH and PCMH+ to non-PCMH and non-PCMH+ providers. In addition, describe the process to analyze and report on health care quality measure for attributed members compared to non-attributed members.

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

I.1. Requirements

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

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

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

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

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

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

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

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

I.1.5. EPSDT Screening Services: Comprehensive, periodic health examinations for members under the age of twenty-one (21) provided in accordance with the requirements of the federal Medicaid statute at 42 U.S.C. § 1396dI(1).

I.1.6. EPSDT Special Services: As required by 42 U.S.C. § 1396I(5), other health care, diagnostic services, preventive services, rehabilitative services, treatment, or other measures described in and coverable pursuant to 42 U.S.C. 1396d(a), that are not otherwise covered under the Connecticut Medicaid Program and that are medically necessary for an individual Medicaid member under age twenty-one (21). The Contractor shall perform specific Utilization Management for EPSDT special services requests and take other actions as are necessary to ensure that Medicaid members under age twenty-one (21) have access to EPSDT special services.

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

I.2.1. To the extent applicable, the Contractor shall authorize all medically necessary coverable medical services that may be recommended or ordered pursuant to an EPSDT periodic or inter-periodic examination including EPSDT special services described in section I.1.6 of this RFP.

I.2.2. The Contractor shall facilitate access to medically necessary health services recommended pursuant to an EPSDT examination when requested by the member or designated representative or when the Contractor otherwise determines that it is necessary and appropriate as follows:

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

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

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

I.2.2.4. Arrange for the provision of EPSDT special services described in section I.1.6 of this RFP by working with the Department to engage the provider and facilitate the provider's enrollment in HUSKY Health on a limited basis to enable the provision of EPSDT special services while also preventing payment for any services not authorized.

I.3. To submit a responsive proposal, the Respondent shall:

I.3.1. Describe process for implementing procedures to effectively inform all members of EPSDT services available under EPSDT. This shall include a detailed description of the processes for informing members in writing, or orally, or a combination thereof.

I.3.2. Describe process for documenting maintaining proof of written communication with each client, including documentation of materials sent, date sent, and to whom the materials were sent.

I.3.3. Describe the processes for ensuring that members eligible for EPSDT services are generally informed of services within sixty (60) days of the member's eligibility determination, and for members who have not used EPSDT services, annually thereafter.

I.3.4. Describe the methods for ensuring that members eligible for EPSDT services with limited English proficiency, visual and hearing impairments will be informed of EPSDT services.

I.3.5. Describe the processes for identifying Children and Youth with Special Health Care Needs to outreach and ensure EPSDT services are provided.

I.3.6. Describe the processes and procedures for aiding with non-emergency medical transportation to members eligible for EPSDT services.

I.3.7. Describe the process for providing scheduling assistance for EPSDT services.

I.3.8. Describe policies and procedures to maintain and improve upon current EPSDT participation and screening ratios for all age groups, including strategies to improve screening rates for adolescents and other hard to reach populations.

I.3.9. Provide a detailed description of how the Contractor has provided EPSDT services.

I.3.10. Provide a detailed description how the Contractor would promote the use of age appropriate developmental and behavioral health screening tools in primary care.

J. REQUIREMENTS FOR OTHER PROGRAMS AND POPULATIONS

J.1. Children's Health Insurance Plan (CHIP) Requirements

The Contractor shall ensure that the families of all HUSKY B enrolled individuals receive information about CHIP benefits and shall inform families about the HUSKY Plus benefit package. HUSKY Plus provides supplemental coverage of goods and services for HUSKY B members whose medical needs go beyond what HUSKY B provides. HUSKY Plus members are medically eligible children with intensive physical health needs or who are Children and Youth Special Health Care Needs. HUSKY Plus Services are not covered under the regular HUSKY plan. Husky Plus is available when HUSKY B services have been exhausted. Current services include case management, long term rehabilitation, home care services, medical and surgical supplies, durable medical equipment, orthotic devices, and hearing aids. Supplemental coverage under HUSKY Plus may change over time and incorporate the covered benefits into the regular HUSKY B benefit package. At the time of the issuance of this RFP, the Connecticut General Assembly is considering legislation to eliminate HUSKY Plus as a separate program.

J.1.1. The Contractor shall inform the families of all CHIP eligible members about the program using written and oral methods, including:

J.1.1.1. Providing families with information about how to obtain health care services for their children and where these services can be obtained.

J.1.1.2. Assisting families with scheduling appointments with health service providers.

J.1.2. The Contractor shall inform the families of all eligible CHIP clients with Children and Youth with Special Health Care Needs about the HUSKY Plus Program about the program using written and oral methods, including:

J.1.2.1. Providing families with information about eligibility requirements.

J.1.2.2. Providing families with information about how to obtain health care services for their children and where these services can be obtained.

J.1.2.3. Assisting families with scheduling appointments with health service providers.

J.1.2.4. Special provision must be made for clients and their families who have limited English proficiency or are hearing or vision impaired. Oral informing techniques may include face-to-face contact, public service announcements, community campaigns and other media.

J.2. Coordination of CHIP Benefits

J.2.1. As a condition of eligibility, CHIP members may not have other comprehensive health coverage. They may have a limited benefits policy, such as dental or vision coverage. The Contractor shall work to coordinate benefits with the appropriate Department agent. If the Contractor learns that any CHIP member has other health coverage, this shall be reported to the Department.

J.2.2. The Contractor shall collect and transfer data on cost sharing with the Department and/or its agent.

J.2.3. The Departments are currently developing service proposals for children and adults that may be funded through the American Rescue Plan Act (ARPA). At the time of issuance of this RFP, those proposals are not yet finalized or funded. The Departments reserve the right to amend this RFP to expand the Scope of Work based on new services funded through ARPA and/or negotiate the inclusion of those services, specifically the role of the ASO related to those services within the Scope of Work, during the contract negotiation process.

J.3. To submit a responsive proposal, the Respondent shall:

J.3.1. Describe the process for implementing procedures to effectively inform all CHIP clients of the services available under CHIP.

J.3.2. Describe the process for documenting and maintaining proof of written communication with each member, including documentation of materials sent, date sent, and to whom the materials were sent.

J.3.3. Describe the methods for ensuring that CHIP members with limited English proficiency or visual and hearing impairments will be informed of CHIP services.

J.3.4. Describe the processes for ensuring that CHIP clients are generally informed of services within sixty (60) days of the member's eligibility determination, and for members who have not used CHIP services, annually thereafter.

J.3.5. Describe the process for providing scheduling assistance for CHIP services.

K. PRENATAL CARE

K.1. Healthy Birth Outcomes

To promote healthy birth outcomes, the Contractor shall:

K.1.1. Identify pregnant members as early as possible in the pregnancy.

K.1.2. Conduct prenatal risk assessments to identify high risk pregnant members, arrange for specialized prenatal care and support services tailored to risk status, and begin care coordination that will continue throughout the pregnancy and early postpartum weeks.

K.1.3. Refer pregnant members to the Women, Infants, and Children (WIC) program.

K.1.4. Offer case management services to assist pregnant members with obtaining prenatal care appointments, transportation, and other support services as necessary such as WIC and Supplemental Nutrition Assistance Program (SNAP).

K.1.5. Offer prenatal health education materials and/or programs to pregnant members aimed at promoting maternal care and healthy birth outcomes.

K.1.6. Offer perinatal and postpartum coaching to low risk members.

K.1.7. Offer case management to high risk pregnant and postpartum members.

K.1.8. Offer HIV and other sexually transmitted disease (STD) testing and counseling and all appropriate treatment to pregnant members.

K.1.9. Refer pregnant members who are actively abusing drugs or alcohol to CT BHP ASO.

K.1.10. Educate members who are new mothers about the importance of the postpartum visit and well-baby care.

K.1.11. Advocate for member's needs and concerns. Ensure that any gaps in care are immediately addressed.

K.1.12. Assess SDOH needs and provide guidance to access resources in the community.

K.1.13. Care Management staff must receive annual training and ongoing in-services regarding health equity and health disparities, implicit bias, improving maternal and infant health outcomes, and adverse maternal outcomes.

K.1.14. Under the direction of the Department, administer the Department's initiatives to improve maternal and newborn health outcomes, including, but not limited to, the Obstetrical Providers Pay for Performance initiative and any bundled payment or other value-based payment method for maternal and newborn care. Such duties include outreach and training for providers, measuring results on the quality measures, evaluating cost savings, performing risk stratification (including risk stratification related to the Integrated Care for Kids (InCK) program and any other applicable program as directed by the Department), provider attribution, and other duties as directed by the Department.

K.1.14.1. Pregnant Women and Infants.

K.1.14.2. Initial claims- based risk stratification and provider attribution

K.1.14.3. Additional risk stratification using an integrated data set, if available

K.1.14.4. Member outreach and assessment in the community

K.1.14.5. Member referral to InCK provider based on member choice/preferences

K.1.14.6. InCK Provider attribution methodology

K.1.14.7. Data analytics to target population including, but not limited to the following:

K.1.14.7.1. Required healthcare outcome measures

K.1.14.7.2. InCK provider engagement rate

K.1.14.7.3. Population comparison analysis with another like cohort (e.g. Bridgeport)

K.1.14.7.4. Total cost of care analysis

K.2. Newborns' and Mothers' Health Protection Act

The ASO shall comply with requirements of the Newborns' and Mothers' Health Protection Act of 1996 regarding requirements for minimum hospital stays for mothers and newborns in accordance with 45 CFR §§ 146.130 and 148.170.

K.3 To submit a responsive proposal, the Respondent shall:

K.3.1. Describe how pregnant women are identified as early in their pregnancy as possible.

K.3.2. Describe successful interventions to increase or promote pre-natal care and how those interventions improved maternal and infant health outcomes, including experience with implementing such interventions, including in the context of value-based payment arrangements, such as performance incentives or bundled payments.

K.3.3. Describe programs to decrease neonatal abstinence syndrome in newborns.

L. COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH CARE

L.1. Overview

Except as otherwise identified in this section and this RFP, care management for behavioral health services for all members will be managed by the behavioral health ASO (Exhibit D)) (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents

L.1.1. The Contractor shall promote coordination of physical health and behavioral health care. Under the direction of the Department, the Contractor will be responsible for coordination with the Behavioral Health Partnership ASO. The Contractor shall promote communication between primary care providers (PCPs) and behavioral health providers and shall support primary care based management of psychiatric medications and services as appropriate (Exhibit D) (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents).

L.1.2. For individuals who access health services and who also have special behavioral health care needs, the Contractor shall help ensure that services are coordinated, that duplication is eliminated, and that lead management is established in cases where co-occurring medical and behavioral needs are serious or complex. Coordination of physical and behavioral health care shall be included in the Contractor's clinical management program.

L.1.3. If there is a conflict between the Contractor and the BHP ASO regarding whether a member's medical or behavioral health condition is primary, the Contractor's medical director shall work with the BHP ASO's medical director to reach a timely and mutually agreeable resolution. If the two ASOs are not able to reach a resolution, the Department will make a binding determination. Issues related to whether a member's medical or behavioral health condition is primary must not delay timely medical necessity determinations. In these circumstances, the Contractor shall render a determination within the standard timeframe required under the contract resulting from this RFP and its policies and procedures. The Contractor shall be responsible for primary care and other services provided by primary care providers in hospitals regardless of diagnosis.

L.1.4. The Contractor shall be responsible for primary care and other services provided by primary care solo and group practitioners and medical clinics, regardless of diagnosis with the following exception. Contractor shall not be responsible for managing behavioral health evaluation and treatment services provided in these settings and billed under CPT codes identified by the Department of Social Services when the member has a primary behavioral health diagnosis and the services are provided by a licensed behavioral health professional. Should there be multiple diagnosis codes on a claim which include both medical and behavioral health, the primary diagnosis code shall determine which Contractor has primary responsibility. However, contractors shall communicate with each other and collaborate on comprehensive treatment for the member.

L.2. Behavioral Health-related Responsibilities of the ASO

L.2.1. Under the direction of the Department, the Contractor shall be responsible for the following behavioral health related activities provided in primary care settings:

L.2.1.1. Behavioral health related prevention and anticipatory guidance.

L.2.1.2. Screening for behavioral health disorders including SBIRT (Screening, brief intervention, and referral to treatment).

L.2.1.3. Treatment of behavioral health disorders that the PCP concludes can be safely and appropriately treated in a primary care setting.

L.2.1.4. Management of psychotropic medications including Prior Authorization in conjunction with treatment by a non-medical behavioral health specialist, when necessary.

L.2.2. The Department will require that the Contractor support the provision of medication management by primary care providers for persons with behavioral disorders when such care can be provided safely and appropriately by such providers.

L.2.3. The Department will require the Contractor and the BHP ASO to work together to identify and manage individuals over utilizing emergency department services for complaints not clearly just medical or behavioral in nature, such as frequent complaints of pain and pain-related symptoms.

L.2.4. The Department will require the BHP ASO to collaborate with the Contractor to coordinate services for individuals with both behavioral health and special physical health care needs.

L.2.5. The Department will require that the Contractor assume responsibility for management of home health services when the home health service is for medical diagnoses alone and when the home health services are required for medical and behavioral diagnoses, but the medical diagnosis is primary or the member's medical treatment needs cannot be safely and effectively managed by the psychiatric nurse or aide.

L.2.6. The Contractor shall not be responsible for management of home health services for a member when the member has a diagnosis of autism spectrum disorder as one of the first three (3) diagnoses.

L.2.7. The Department will require the Contractor to manage all ancillary services such as laboratory, radiology, and medical equipment, devices and supplies regardless of diagnosis.

L.3. Coordination with CT BHP ASO

L.3.1. Under the direction of the Department, the Contractor shall communicate and coordinate with the CT BHP ASO and the Department's BHP ASO contract manager as necessary to ensure the effective coordination of medical and behavioral health for individuals with both behavioral health and special physical health care needs. The DSS BHP contract managers will facilitate all communications between ASOs.

L.3.2. The Contractor shall collaborate with the Department or the BHP ASO to coordinate hospital inpatient services, ED services, laboratory services and other services administered by the BHP.

L.3.3. The Contractor shall provide for all necessary aspects of coordination between the Contractor and the BHP. The details of such coordination shall be set forth by the Contractor in its Behavioral and Physical Health Coordination Program, which shall be submitted to the Department for their review and approval at such time as determined by the Department. Specifically, the Contractor shall:

L.3.3.1. Contact the appropriate BHP ASO staff when co-management of a member is indicated, such as for persons with special physical health and behavioral health care needs.

L.3.3.2. Respond to inquiries by the BHP ASO regarding the presence of co-occurring behavioral health conditions.

L.3.3.3. Coordinate management activities and services with the BHP ASO when requested by the BHP ASO.

L.3.3.4. Promote and support coordination between medical providers and the behavioral health providers as appropriate.

L.3.3.5. Participate with the BHP ASO in the development of policies pertaining to coordination between the Contractor and the BHP ASO and shall adhere to such policies as approved by all parties, and as they may be revised from time to time.

L.4. To submit a responsive proposal, the Respondent shall:

L.4.1. Provide a plan to facilitate the coordination of services for individuals with both behavioral health and physical health care needs. The plan should address:

L.4.1.1. Screening tools for use in primary care and recommendations for their use.

L.4.1.2. Proposed protocols for communication between primary care and behavioral health providers.

L.4.1.3. Identification of medical conditions that require behavioral health screening or assessments.

L.4.1.4. Recommendations for working with primary care providers whose clients might not normally seek behavioral health services due to generational, ethnic, racial, cultural, or other background or any combination of factors that are associated with individuals being less likely to seek behavioral health services to make the behavioral health services available in the primary care setting or to facilitate access elsewhere.

M. COORDINATION WITH THE DENTAL ASO

M.1. Coordination with the dental ASO

M.1.1. The Contractor shall be responsible for coordination of the health care needs of individuals with the dental ASO. Except as otherwise identified in this section and this RFP, care management for dental health services for all members will be managed by the dental health ASO and dental services shall be managed by the dental ASO. The Contractor shall:

M.1.1.1. Communicate and coordinate with the dental ASO contract manager as necessary to ensure the effective coordination of medical and dental health benefits.

M.1.1.2. Provide appropriate education and guidance to primary care providers with the participation of the Department or the dental ASO.

M.1.1.3. In coordination with the Department or the dental ASO, develop guidelines for primary care-based screening and treatment of dental health disorders including indications for referral to a dental health specialist, and procedures for referrals.

M.1.1.4. The Contractor shall convene and provide input with the dental ASO in coordination with the Department's dental ASO contract manager to identify members with chronic or acute medical conditions which are known to be correlated to comorbidities in the absence of routine preventive dental services.

M.1.2. The Department will require the dental ASO and the Contractor to collaborate with the coordination of services for individuals with both dental health and special health care needs.

M.2. To submit a responsive proposal, the Respondent shall:

M.2.1. Provide a plan to facilitate the coordination of services for individuals with both dental health and special physical health care needs. The plan should:

M.2.1.1. Offer dental screening practices for use in primary care and recommendations for their use.

M.2.1.2. Provide proposed protocols for communication between primary care and dental health providers.

M.2.1.3. Include missed dental visits in the gaps in care analysis and reporting available to primary care providers.

M.2.1.4. Identify medical conditions which should trigger special dental health assessments such as pregnancy, as well as dental health concerns or findings which should trigger communications with primary care providers.

M.2.1.5. Provide recommendations for working with primary care providers whose clients might not normally seek dental health services due to generational, ethnic, racial, or cultural background to make the dental health services available in the primary care setting or to facilitate access elsewhere.

N. COORDINATION WITH HOME AND COMMUNITY BASED WAIVER PROGRAMS

N.1. Coordination Agreements

N.1.1. The Contractor shall develop coordination agreements with the Department of Developmental Services and the Department of Mental Health and Addiction Services with respect to the management of services for individuals participating in DDS or DMHAS administered Home and Community Based Waiver (HCBW) programs pursuant to section 1915I of the Social Security Act.

N.2. Other Coordination Responsibilities

N.2.1. The Contractor shall be required to coordinate with all home and community-based services programs administered by the Department, including, but not limited to, the Acquired Brain Injury waiver program, the Connecticut Home Care Program for Elders, the Personal Care Assistance waiver, the Money Follows the Person project, Community First Choice, and any other HCBS programs that may be established by the Department during the period of the contract resulting from this RFP. This shall include, but not be limited to referral of potential clients to these programs to maximize community-based care.

N.2.2. The Contractor shall be required to refer clients who could potentially benefit from waiver participation to the appropriate waiver.

N.3. To submit a responsive proposal, the Respondent shall:

N.3.1 Provide examples of previous experience with coordination and referral with home and community-based Medicaid programs.

N.3.2. Describe experience with coordination of home and community-based waiver programs. How has this coordination benefited Medicaid members?

O. QUALITY MANAGEMENT

O.1. Quality Management (QM)

Quality Management (QM) refers to a comprehensive program of quality and cost measurement, quality improvement and quality assurance activities responsive to the Department's objectives. The Department seeks to ensure that all individuals receive appropriate, effective, medically necessary, and cost-effective treatment to maximize health outcomes. The Contractor will systematically and objectively measure access to care, demand for services, quality of care, and outcomes and analyze utilization data, satisfaction surveys, complaints, and other sources of quality information. This information will support the development of continuous quality improvement strategies by the Respondent and by providers that are consistent with the vision and mission of the Department. The primary focus of the Respondent's quality management activities will include:

O.1.1. Population health improvement as outlined in section A.1.1.

O.1.2. Statewide quality initiatives focused on improving access to well visits, health screens, prenatal care, and care for common illnesses with significant prevalence in or importance to HUSKY Health members as determined by the Department, such as diabetes and asthma.

O.1.3. Provider profiling to support quality improvement, pay-for-performance initiatives, and other value-based payment or other quality initiatives.

O.1.4. Performance measurement of PCMH, PCMH+ providers, and other provider categories as designated by the Department.

O.1.5. Statewide performance measurement with respect to access, quality and cost.

O.2. Quality Management Oversight

The Department shall:

O.2.1. Review for approval prior to implementation the Contractor's QM Program description that incorporates its initiatives, strategies, staff time and organization, methodologies for on-going quality assurance, quality improvement, and performance assessment activities.

O.2.2. Require the Contractor to study and evaluate issues that the Department may from time to time identify.

O.2.3. Develop post-implementation quality indicators to monitor performance during the first nine (9) months post-implementation and on an ongoing basis as required by the Department.

O.2.4. Establish annual performance targets as described in the Performance Targets (Exhibit A) (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents) and Withhold section.

O.2.5. Review for approval all member and provider surveys.

O.3. General Provisions

The Contractor shall:

O.3.1. No later than January 1, 2022, provide the Department, for its review and approval, a written description of the QM Program including the program structure and processes that explain the accountability of each committee or organizational unit; functional relationships between each committee and organizational unit; policies and procedures and the mechanisms for obtaining input from member and provider groups.

O.3.2. In consultation with the Department, develop performance measures and indicators of a person-centered care system and approach, to be integrated into the QM Program.

O.3.3. Develop mechanisms to track and monitor the post-implementation quality indicators.

O.3.4. Employ a full-time qualified QM Director responsible for the operation and success of the QM program. The QM Director must possess an advanced degree in a field of study relevant to human services and demonstrate at least five (5) years of experience in the development and implementation of quality management programs, including participating in audited HEDIS surveys.

O.3.5. Participate in the Department's QM Committee as requested by the Department to report on all QM activities that are part of the Annual Quality Management Program Plan or to review other issues identified by the Department or the Contractor.

O.4. Annual Quality Management Project Plan and Program Evaluation

The Contractor shall:

O.4.1. By March 1, 2022 and annually thereafter, propose to the Department for its review and approval an Annual Quality Management Project Plan that outlines the objectives and scope of planned projects. The Annual Quality Management Project Plan shall describe how the Contractor will conduct:

O.4.1.1. Member satisfaction surveys (program wide and specific to an individual's person-centered medical home, PCP, or other applicable providers.

N.4.1.2. Provider satisfaction surveys.

O.4.1.3. Measurement of access, quality, care experience and outcomes (program wide and specific to an individual's medical/health home).

O.4.1.4. Clinical Issue Studies. Ongoing Quality Management Activities.

O.4.1.5. Quality Improvement Initiatives (beginning in year two).

O.4.2. The Contractor shall by April 1, 2022 and annually thereafter, provide a Quality Management Program Evaluation.

O.5. Member Satisfaction Surveys

O.5.1. The Contractor shall conduct annual member Satisfaction Surveys.

O.5.2. The Contractor shall report the results of such surveys to the Department. The Satisfaction Surveys shall be conducted within the following guidelines:

O.5.2.1. Level of aggregation

O.5.2.1.1. The Contractor shall measure and report to the Department on the satisfaction of members once during each contract year using the CAHPS or similar instrument approved by the Department and using a stratified sample (such as specified by HUSKY A, HUSKY B, HUSKY C, and HUSKY D) of all members statewide.

O.5.2.1.2. The Contractor shall also measure the satisfaction of members enrolled in or attributed to each person-centered medical home/PCP once during each contract year using the CAHPS or similar instrument approved by the Department.

O.5.2.1.3. The Contractor shall also measure the satisfaction of members who have contacted the service center for assistance. This brief measure will be provided by the Department. The results of this assessment may be the basis for return of a portion of the withhold as established in Exhibit A. (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents)

O.5.2.2. Frequency

O.5.2.2.1. The Contractor shall measure the satisfaction of members once during each contract year.

O.5.2.3. Implementation

O.5.2.3.1. The Contractor shall commence the collection of member satisfaction survey data by March 1, 2012 and annually thereafter.

O.5.2.3.2. The Contractor shall complete the data collection, analysis, interpretation, and final reporting to the Department by December 31, 2022 and annually thereafter.

O.5.2.3.3. The Contractor will propose a corrective action plan for the Department's approval, which will be implemented by the Contractor and/or the Department, as appropriate.

O.5.2.4. Methodology

O.5.2.4.1. The methodology utilized by the Respondent shall be based on generally recognized and accepted research methods that ensure an adequate sample size and statistically valid and reliable data collection practices.

O.6. Provider Satisfaction Surveys

O.6.1. The Contractor shall conduct, and report to the Department the results of, an annual provider satisfaction survey using a provider survey instrument approved by the Department. The survey shall, at a minimum, address the provider's satisfaction with the Contractor's services and other administrative services provided by the state or its agents including but not limited to authorization procedures, courtesy and professionalism, network management services, provider appeals, provider education, referral assistance, coordination, claims processing as administered by the Department's MMIS) and overall administrative burden. The first survey will be conducted by October 31, 2022 and annually thereafter.

O.6.2. The Contractor will propose a corrective action plan for the Department's approval, which will be implemented by the Contractor and/or the Department, as appropriate.

O.7. Clinical Issue Studies

O.7.1. The Contractor shall propose to the Department for its approval at least three (3) annual clinical issue studies beginning in year one of the contract. Please provide examples of recent studies.

O.7.2. The Contractor shall during each year of the contract resulting from this RFP:

O.7.2.1. Propose to the Department the scope of the clinical issue studies by March 1.

O.7.2.2. Submit to the Department by June 1st of each calendar year in the contract, or such other date as agreed to by the Department and the Contractor, for their review and approval, a draft of the study report for each clinical issue study. The study report shall, at a minimum, include recommendations for intervention.

O.7.2.3. Implement the report recommendations upon approval by the Department.

O.7.3. The Contractor shall use a methodology based on accepted research practices ensuring an adequate sample size and statistically valid and reliable data collection practices.

O.7.4. The Contractor shall use measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate.

O.8. Ongoing Quality Management Activities

O.8.1. The Contractor shall prioritize, monitor, analyze and document problems identified by the UM, ICM, Provider Relations, and member Services Units, as well as problems identified through the complaints process.

O.8.2. Complaints related to access (lack of access or delays in access) must be categorized at a minimum as to service type and/or specialty (e.g., primary care, cardiology, orthopedics), client age (pediatric, adult, geriatric), and locality.

O.8.3. The Contractor shall propose to the Department recommendations on innovative strategies related to Utilization Management, Care Management and Case Management based on national trends and evidence-based practice.

O.8.4. The Contractor must continuously monitor all aspects of HUSKY Health and use data obtained to identify opportunities for improvement. This data includes analysis of information obtained through direct provider and patient contact as well as through claims.

O.8.5. The Contractor shall investigate and address access and quality of care issues. On-site reviews of quality of care issues conducted by the Contractor must take place during normal business hours with at least twenty-four (24) hours advance notice.

O.8.6. On behalf of the Department, the Contractor may:

O.8.6.1. Review the quality of care rendered by the provider, including but not limited to chart audits.

O.8.6.2. Conduct visits at the provider's service site.

O.8.6.3. Require corrective action plans of the provider.

O.8.6.4. Suspend referrals, registration, or authorizations.

O.8.6.5. Report to the Department if issues are of a serious nature or remain unresolved.

O.9. Quality Improvement Initiatives

O.9.1. The Contractor shall identify, prioritize and submit for the Department's review and approval, as part of its Annual Quality Management Project Plan, quality initiatives based on:

O.9.1.1. Data and experience available through the Department and the Contractor's experience in Connecticut and other states, if applicable.

O.9.1.2. The results of the member and provider satisfaction surveys.

O.9.1.3. The results of the clinical issues studies.

O.9.1.4. Recommendations derived from the analysis of problems identified by the UM, ICM, Network Management, Provider Relations, Member Services Units, and through the complaints process.

O.9.2. The Contractor shall emphasize reduction of ethnic and racial health disparities in all quality improvement initiatives.

O.9.3. The Contractor shall implement quality improvement initiatives starting in year one of the contract in coordination with and with the approval of the Department. Initial quality improvement initiatives can be in the areas below but other initiatives can be suggested or recommend by the Department including but not limited to individuals with higher cost and/or needs Please provide additional examples of quality improvement initiatives implemented in other Medicaid states.

O.9.3.1. Chronic pain management.

O.9.3.2. Breast, cervical, and colon cancer screening.

O.9.3.3. Tobacco cessation.

O.9.3.4. Depression screening.

O.9.3.5. EPSDT well visits.

O.9.3.6. Adult well visits.

O.9.3.7. Comprehensive diabetes care.

O.9.3.8. Asthma care.

O.9.3.9. Prenatal and postnatal care.

O.9.4. In coordination with the Department, the quality improvement initiatives conducted by the Contractor pursuant to this section will also include broad initiatives to improve population health and address challenges with Social Determinants of Health among HUSKY Health Members in specific areas to be determined, which may include initiatives in one or more of the following or other areas: training providers to help Members prevent unplanned pregnancies, engaging in initiatives to improve Members' access to healthy food, and other areas to be determined.

O.10. Provider Profiling

O.10.1. The Contractor shall, by February 1, 2022, and annually thereafter, produce for the Department a provider profiling strategy and methodology for review and approval.

O.10.2. The Contractor shall work collaboratively with the provider and consumer stakeholders to inform the provider profiling methodology.

O.10.3. The Contractor shall, at a minimum, develop provider profiles in two areas each contract year to be determined annually.

O.10.4. The Contractor's Program Managers (see O.13) shall share profiling results with providers, advise in the provider's development of continuous quality improvement plans and support providers and communities in the execution of the plans.

O.10.5. The profiling system shall enable the Department to profile provider performance and shall also support provider self-profiling.

O.11. Person Centered Medical Home/PCMH+ Performance Measurement

O.11.1. The Contractor shall, by January 1, 2022, and annually thereafter, produce for the Department a PCMH/PCMH+ performance measurement strategy and methodology for review and approval.

O.11.1.1. The performance measurement strategy shall encompass the range of PCMH/PCMH+ performance measures established by the Department.

O.11.2. The Contractor shall work collaboratively with the PCMH/PCMH+ providers and consumer stakeholders to inform the performance measurement methodology.

O.11.3. The Contractor's Program Managers shall share profiling results with providers to support providers and community's continuous quality improvement activities.

O.11.4. The profiling system shall enable the Department to profile PCMH/PCMH+ performance and shall also support PCMH/PCMH+ self-profile.

O.12. Statewide Performance Measurement

O.12.1. The Contractor shall, by January 1, 2022, and annually thereafter, produce for the Department a statewide profiling strategy and methodology for review and approval.

O.12.1.1. The profiling strategy shall encompass the range of performance measures contained in Exhibit E (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents)

Reporting Matrix as amended by the Department in consultation with the Medicaid Care Management Oversight Council.

O.12.2. The Contractor will be required to carry out the full complement of audited HEDIS Medicaid measures including hybrid measures in accordance with NCQA standards.

O.12.3. The Contractor shall use claims data provided by the Department and shall contract with an NCQA accredited auditor or similar entity.

O.12.4. The Contractor shall contract for or use the Contractor's quality management staff to undertake all field-based chart reviews and other document reviews as necessary to meet the HEDIS requirements.

O.12.5. In consultation with the Department, the Contractor shall include patient-reported outcomes and experiences measurement to the full extent feasible and appropriate as part of its quality measurement activities.

O.13. Program Managers

O.13.1. The Contractor shall employ enough Program Managers to conduct the provider and PCMH/PCMH+ profiling activities outlined in O.10 and O.11.

O.13.2. The Contractor shall provide the Program Managers with training and ongoing supervision to support their role in analyzing network information, developing quality improvement plans, monitoring of critical incidents, and promoting the development of best practices within provider organizations.

O.13.3. The Contractor shall ensure that applicants for the Program Manager positions have:

O.13.3.1. Significant experience in the field of health and care management.

O.13.3.2. Demonstrated leadership and accomplishments in the management of health services.

O.13.3.3. Expertise in basic data analysis and reporting.

O.13.3.4. Demonstrated experience in helping to develop a continua of health systems in which a full continuum of care is available across all applicable levels of care.

O.13.3.5. Demonstrated experience in quality management of healthcare providers. As part of its overall functions, including, but not limited to Clinical Management and Quality Management, under the direction of the Department, the Contractor shall identify, report, and take applicable action to promote program integrity within HUSKY Health. Examples of program integrity include immediately reporting suspected fraud, overbilling, or other non-compliance with HUSKY Health requirements to the Department and fully cooperating and assisting with any investigations into HUSKY Health providers related to any such non-compliance.

O.13.3.6. The ability to develop and implement performance improvement plans for providers.

O.13.3.7. Experience in organizing and coordinating meetings while promoting communication and collaboration among stakeholders.

O.14. Annual Quality Management Project Plan Evaluation

O.14.1. The Contractor shall submit to the Department according to the schedule provided in the Reporting Matrix at Exhibit E (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents) a comprehensive QM Program Evaluation Report utilizing the performance measures detailed in the Contractor's QM Plan. The evaluation components shall correspond to the components and to the schedule outlined in the approved Annual Quality Management Program Plan.

O.14.2. At a minimum the evaluation report shall include the following:

O.14.2.1. A description of completed and ongoing Provider and Member Surveys, Clinical Issue Studies, Ongoing QM Activities and annual QM Initiatives.

O.14.2.2. Summary of improvements in access, quality of care, coordination of physical and behavioral healthcare, and performance in other areas as a result of Ongoing QM Activities and QM Initiatives and evaluation of the overall effectiveness of the Annual Quality Management Program Plan.

O.14.2.3. Summary of other trends in access, utilization, and quality of care (including but not limited to measures contained in the Reporting Matrix – Exhibit E (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents) that provides an overall illustration of the performance of HUSKY Health providers.

O.14.2.4. Assessment of utilization and other indicators that suggest patterns of potential inappropriate utilization and other types of utilization problems.

O.14.2.5. Assessment of provider network adequacy including instances of delayed service and transfers to higher or lower levels of care due to network inadequacy, adequacy of linguistic capacity, and cultural capacity of specialized outpatient services.

O.14.2.6. Assessment of provider network access based on standards defined by the Department. Access standards apply to life threatening and non-life-threatening emergency care services, urgent care services and routine care services.

O.14.2.7. Evaluation of the Contractor's performance with respect to targets and standards described in the Reporting Matrix (Exhibit E) (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents), with proposed interventions to improve performance (corrective action plans) and proposed intervention measures.

O.14.2.8. Proposed QM initiatives and corrective actions including proactive action to improve member clinical functioning, sustain recovery, minimize crises and avert adverse outcomes and to remediate utilization problems; and overall impression of the ASO's system operations and functioning with recommendations for remediation.

O.15. Critical Incidents

O.15.1. The Contractor shall report to the Department any critical incident within one (1) hour of becoming aware of the incident. A critical incident is an unexpected occurrence in which a member's life, physical health or mental health wherein imminent danger or if a member was harmed in a manner which required immediate and intensive medical care or resulted in death. The Contractor shall report the specific details of the incident to DSD including details of the provider and/or facility if applicable. Examples include falls with injuries, patient abuse from a provider, or member receiving a wrong treatment in a hospital setting which lead to significant harm. Critical incidents are also reported to the Department of Public Health.

O.15.2 The Contractor shall report to the Department all significant incidents within one (1) hour of becoming aware of the incident. A significant event is a preventable event but does not place the member in imminent danger. For example, a member may have difficulty accessing covered services.

O.15.3. The Contractor shall report to the Department, on a quarterly and annual basis, critical incidents and significant events in the aggregate. Reports shall be submitted in accordance with timeframes outlined in the Reporting Matrix (Exhibit E) https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents.

O.16. To submit a responsive proposal, the Respondent shall:

O.16.1. Propose a QM Program Plan outline based on the Respondent's previous experience and modified to be responsive to this application.

O.16.2. Propose quality indicators and methods that might serve as effective measures of successful implementation during the first nine (9) months of implementation.

O.16.3. Propose a methodology for meeting the requirements of the Annual QM Program Plan.

O.16.4. Propose a survey methodology for obtaining member and provider satisfaction and feedback regarding access, quality and the care experience.

O.16.5. Provide a flow chart and describe how the Respondent will track, monitor, respond and resolve all complaints. The Respondent shall identify if this process is manual or automated and describe each process in detail. This could include segregating those complaints that can be resolved by the Contractor versus those that would require the Department's assistance.

O.16.6. Propose a methodology to identify Clinical Study issues. (O.7.1)

O.16.7. Propose a methodology to identify members with multiple emergency department admissions and identify and refer for ICM high-risk members with multiple chronic conditions/co-occurring medical/behavioral health needs.

O.16.8. Propose position description and qualifications for program managers.

O.16.9. Propose a methodology and plan to identify and address provider relations issues (i.e., authorization problems, enrollment problems, data exchange problems and other issues).

O.16.10. Propose a methodology, including specific material, reports, data and events to initiate desk or on-site provider quality audits in response to quality of care complaints or incidents to improve the quality of care at specific provider sites.

O.16.11. Propose a methodology that clearly describes the process for establishing corrective action plans, and if necessary, provider sanctions based on the quality audit and subsequent findings.

O.16.12. Describe the proposed approach to conducting the required provider profiling activities as stated above.

O.16.13. Describe the proposed approach to conducting the required PCMH/PCMH+ performance measurement activities as stated above.

O.16.14. Describe the proposed approach to conducting the required statewide performance measurement.

> O.16.14.1. Include specific information regarding how the Contractor will administer this requirement using claims data provided by the Department and detail the plan for the gathering of information necessary to satisfy all measure requirements.

O.16.15. Describe how the provider profiling and PCMH/PCMH+ performance measurement system can be accessed by the Department for use in profiling individual providers and PCMH/PCMH+ providers.

O.16.16. Describe how the provider profiling and PCMH/PCMH+ performance measurement system can be accessed by providers to support their ongoing performance monitoring and quality improvement.

O.16.17. Describe whether and how this system might facilitate comparison with other similar providers or levels of care statewide.

P. PROVIDER RELATIONS

P.1. Introduction

P.1.1. The success of the ASO depends upon adequate member access to providers practicing the highest standards of clinical care. The Contractor therefore must emphasize retention and recruitment of high-quality providers within the HUSKY Health provider network.

P.1.2. Throughout the term of the contract, the Contractor shall develop and maintain positive Contractor-Provider Relations; communicate with all providers in a professional and respectful manner; promote positive provider practices through communication and mutual education and provide administrative services in the most efficient manner possible in an effort to pose minimal burden on providers while adhering to all applicable requirements and procedures.

P.2. General Aims

P.2.1. The Contractor shall promote on-going and seamless communication between providers and the Contractor. To accomplish this task the Contractor shall:

P.2.1.1. Include providers in the Contractor's committee structure, to give providers a direct voice in providing input to the Contractor in developing, monitoring, and updating clinical policies.

P.2.1.2. Offer providers on-site consultation with respect to both clinical and administrative issues.

P.2.1.3. Work with providers to reduce administrative responsibilities using the Contractor's bypass program, interactive voice response (IVR) system, Web-enabled registration systems, and other technologies.

P.2.1.4. Provide encryption software upon request from a provider to provide for the exchange of member data via e-mail.

P.2.1.5. Post all policies and procedures, handbooks and other material, produced as a requirement under the contract resulting from this RFP and as determined by the Department, on the ASO Website. Provider websites must be readily and clearly accessible in a manner that allows providers quick access to important information.

P.2.1.6. Make all policies and procedures, handbooks and other material produced as a requirement under the contract resulting from this RFP and as determined by the Department, available to providers in electronic and written hard copy, if requested.

P.2.1.6.1. To the greatest extent possible, notify providers of impending policy or procedural changes at least forty-five (45) days prior to implementation.

P.2.1.7. Monitor Provider complaints and if, in the opinion of the Contractor, the complaints are of sufficient severity or frequency to warrant consideration for disenrollment from the CMAP network, notify the Department of the Contractor's findings and recommendations.

P.2.1.8. Conduct provider satisfaction surveys at least once per year, sharing findings with provider advisors and involve the provider advisors in implementing corrective action as indicated.

P.2.1.9. Beginning January 1, 2022, provide the Department with a publication-ready newsletter for review and approval twice a year.

P.2.1.9.1. The Contractor shall ensure that the newsletter includes articles covering health topics of interest for providers who work both with children and adults, that appropriate medical professionals are involved in writing the assigned articles, and that the newsletters are posted to the ASO website once approved by the Department.

P.2.1.10. Assist the Department with monitoring and training the provider community by offering individualized training to providers, targeting high volume providers or those providers with specific needs identified through monitoring reports, and tracking and monitoring all complaints as part of re-credentialing, and inform the Department if intervention is required in an urgent situation.

P.3. Provider Handbook

P.3.1. The Contractor shall, by January 1, 2022, produce a Provider Handbook for the Department's review and approval prior to its distribution, and shall make this handbook available on the website.

P.3.2. The Contractor shall make the printed form of this handbook available for distribution upon request.

P.3.3. The Provider Handbook shall include at least each of the following topics:

P.3.3.1. Contractor corporate information.

P.3.3.2. Confidentiality provisions.

P.3.3.3. Mission statements of the Department and the ASO.

P.3.3.4. Descriptive process for accessing services under the ASO.

P.3.3.5. Procedures for communicating with the Department and the ASO.

P.3.3.6. Summary of service and benefit structure.

P.3.3.7. Description of formularies or preferred drug lists for enrolled members.

P.3.3.8. Procedures for submitting complaints, requests for reevaluation, and appeals.

P.3.3.9. Procedures for service authorization and registration.

P.3.3.10. Procedures for using web-based provider services.

P.3.3.11. Summary of UM requirements.

P.3.3.12. Summary of claims procedures and the Department's MMIS Contractor contact information.

P.3.3.13. Names and contact information of Provider Relations staff.

P.3.3.14. Information on how members may access pharmacy, transportation, behavioral and dental services.

P.4. Provider Notification

P.4.1. Throughout the term of the contract resulting from this RFP, the Contractor shall be required to alert providers to modifications in the Provider Handbook and to changes in provider requirements that are not otherwise communicated by the Department or its MMIS Contractor. To accomplish this task the Contractor shall:

P.4.1.1. Request and obtain from providers an e-mail address, so they can be alerted to access the Contractor's ASO Website to download updates to the provider handbook, provider bulletins, and provider requirements.

P.4.1.2. E-mail to providers and publish on the Contractor's ASO Website any clarification or direction on matters not otherwise communicated by the Department.

P.4.1.3. Post notification of policy changes on the Contractor's ASO Website.

P.5. Provider Training and Targeted Technical Assistance

P.5.1. Throughout the term of the contract the Contractor shall:

P.5.1.1. Offer training and technical assistance to providers on clinical topics, including introducing evidence-based and emerging best practices and any changes in procedures, criteria, or requirements, as approved by the Department,

P.5.1.2. Offer training and technical assistance to providers on a person-centered approach to care, as approved by the Department.

P.5.1.3. Develop and implement an ongoing program of provider workshops and training sessions designed to meet the specialized needs and interests of providers, including

training specifically designed for providers who recently enrolled in HUSKY Health and training for categories of providers where there is a demonstrated need for training.

P.5.1.4. Have available both clinical and administrative staff to provide targeted technical assistance onsite at the request of enrolled HUSKY Health providers and providers seeking to enroll as HUSKY Health providers.

P.6. Provider Inquiries and Complaints

P.6.1. Throughout the term of the Contract the Contractor shall:

P.6.2. Using a reporting grid to be developed by the Department, track and manage all provider inquiries and complaints related to clinical and administrative services covered under the contract resulting from this RFP, and direct all complaints related to behavioral health, pharmacy, dental and transportation services to the responsible Department vendor.

P.6.3. Ensure that all provider inquiries and complaints are addressed and resolved in compliance with the Contractor's approved QM Plan, and no later than 30 days from receipt.

P.6.4. Ensure that all Provider inquiries and complaints are addressed and resolved in compliance with the Contractor's approved QM Plan and no later than 30 days from receipt.

P.6.5. Provide the Department with a regular report outlining the Contractor's compliance with required timeframes and notifications related to inquiries and complaints. The Department and the Contractor shall agree to the form, content and frequency of the report in advance.

P.6.6. Utilize the Contractor's management information system(s) (MIS) to track complaint related information and provide this data to the Department upon request. Such data shall include at least the following elements:

P.6.6.1. Name and affiliation of the person making the complaint.

P.6.6.2. Date and Time of complaint.

P.6.6.3. The nature of the complaint.

P.6.6.4. Category/type of complaint including information regarding location and specific professional service type if complaints relate to access.

P.6.6.5. Actions taken to address complaint.

P.6.6.6. Complaint resolution outcome, date and time.

P.6.6.7. Narrative details regarding complaint.

P.7. Web-based Communication Solution

P.7.1. By January 1, 2022 the Contractor shall develop and implement a Website specifically to serve ASO providers and members and register the address https://www.huskyhealthct.org (hereinafter referred to as the "ASO Website"). All websites and domains remain the property of the Department.

P.7.2. The Contractor shall ensure that the ASO Website provides information about the Contractor's services, a link to the Department's primary websites and other related websites for HUSKY Health, including links to each of the websites operated by the Department's other ASOs, the Department's MMIS Contractor, the Department's NEMT broker, pharmacy benefit website, website for Access Health CT, and other applicable websites as designated by the Department () and a link to the Contractor's corporate website. Coordination of this for the Department's websites should be done through the Department's Webmaster.

P.7.3. The Contractor shall, in collaboration with and subject to the approval of the Department, determine what program content is to be published on the ASO Website.

P.7.4. The Contractor shall provide Web-enabled transactional capabilities through the ASO Website. Such capabilities shall include at least the following:

P.7.4.1. Provider/member inquiries and complaints.

P.7.4.2. Submission of initial and subsequent requests for authorization, concurrent review registration and re-registration to the extent that one or more of those are required for applicable covered services by the Department and the ability to update information in requests, correspond between the provider and Contractor, view the Contractor's decisions, and initiate requests for reevaluation.

P.7.4.3. Authorization/registration provider look-up capability, including authorization/registration number, authorization status indicator for pending authorizations, begin and end dates, number of units authorized, units available (or used), and payable codes under authorization, and the ability for providers to select the option of having email or other alerts to notify them about changes in the status of authorization and other utilization management requests and approval status.

P.7.4.4. Electronic Transport System (ETS), a communication system designed for the interchange of electronic data files between providers and the Department.

P.7.4.5. Contractor's Online Provider Services application to allow providers to register care and verify eligibility online and to submit requests for continued care beyond the initially authorized/registered services.

P.7.4.6. A Web-based referral search system that will allow Contractor's and Department's staff, providers, members and any other interested persons to locate network providers through an online searchable database. The Contractor shall be responsible for updating a Department Provider Directory with pertinent information so members will have up to date provider information.

P.7.4.6.1. The searchable database shall include providers enrolled in HUSKY Health, with information regarding areas of clinical specialization, race/ethnicity, gender, languages spoken, disciplines, program types, locations, and whether the provider is accepting new HUSKY Health patients. (The Contractor will work with the Department to endure definitions are current and may need to be updated.)

P.7.4.6.2. The system shall permit searches using any combination of the following criteria: provider type (e.g., hospital, clinic, physician and others as determined by the Department); specialty (e.g., primary care physician, specialist, or other description which further defines a provider's clinical expertise as determined by the Department); zip code; languages spoken; sex of provider; ethnicity of provider; last name; and first name.

P.7.4.6.3. Persons accessing the referral search system shall be able to sort provider search results by travel options (public transportation, walking, driving distance), list the details available on each provider (e.g., specialties and languages), and include a map showing locations of provider offices in relation to a specified location.

P.7.4.6.4. Providers shall have the ability to securely initiate updates of the provider's information in the searchable database including the ability to provide telehealth services.

P.7.4.6.5. The Contractor shall ensure that the Website includes an internet "library" of health information for providers, ASO members, families and the Department's staff. The library shall provide comprehensive information and practical recommendations related to health conditions, wellness, and services in both English and Spanish.

P.7.4.6.6. The Contractor will facilitate at least two (2) peer learning initiatives per year in specific practice areas mutually agreed upon by the Contractor and the Department.

P.8. **To submit a responsive proposal, the Respondent shall**:

P.8.1. Propose method(s) for providing on-going and seamless communication between providers and the Contractor, including, but not limited to, a web-based provider portal.

P.8.2. Propose how a secure provider portal that would transmit member level data to applicable providers would enhance member care and outcomes.

P.8.3. Propose a provider notification process.

P.8.4. Propose a plan for an orientation program and targeted technical assistance for providers with specific attention to engaging providers.

P.8.5. Propose a methodology to identify providers who require targeted training.

P.8.6. Propose a plan to assist with the facilitation of biannual regional community meetings for the purposes of information sharing and feedback with providers, consumers, and advocacy groups.

P.8.7. Propose a mechanism to track and manage all provider inquiries, complaints and/or grievances.

P.8.8. Propose a web-based solution to address communication needs of providers including the way the Respondent's Connecticut website will relate to the Respondent's entire web address and the ASO website.

P.8.9. Propose two (2) peer learning initiatives in the first year of the contract that would enhance services to members.

Q. PROVIDER NETWORK DEVELOPMENT

Q.1. Introduction

Q.1.1. The success of the ASO depends upon adequate client access to providers practicing the highest standards of clinical care. The Contractor therefore must emphasize retention and recruitment of high-quality providers. Throughout the term of the Contract, the Contractor shall provide network management and development functions, including the development of a provider file, qualifications review, assess demand, network adequacy analysis, and network development assistance.

Q.1.2. The Contractor shall facilitate expansion of the HUSKY Health provider network to support adequate client access to a complete range of provider types and specialties, as defined based on the Department's access requirements that will be set forth in the contract that will result from this RFP.

Q.1.3. The Contractor shall provide technical assistance in the field to providers and data to support the emergence and ongoing operations of person-centered medical home (PCMH) practices, person-centered medical home plus (PCMH+) participating entities, and other service delivery innovations and quality improvement initiatives implemented by the Department. This technical assistance includes specific assistance on the PCMH glide path to help primary care practices that are seeking to become recognized PCMH practices. Related to these duties, under the direction of the Department, the Contractor shall also provide data analytics, clinical analysis, recommendations, and other specified assistance related to the Department's implementation of new initiatives within HUSKY Health and improvements to existing elements of HUSKY Health.

Q.1.4. The Contractor shall interact with the providers solely in its capacity as an administrative agent on behalf of the Department. In this capacity, the Contractor shall assist the Department in developing and maintaining the provider network sufficient to ensure the delivery of all covered services to all members, including developing and maintaining sufficient PCMH practices and PCMH+ participating entities, as well as performing all other required functions of the medical ASO that will be set forth in the contract that results from this RFP.

Q.1.5. In order to ensure that there are no actual or potential conflicts of interest between the Contractor and HUSKY Health providers, the Contractor shall not subcontract its responsibilities as a medical ASO with HUSKY Health enrolled providers, except in the limited context that, subject to the Department's prior written approval, the Contractor may contract with individual physicians or other applicable licensed clinicians for whom it is not feasible for the Contractor to

hire as employees for clinical consultation and only if the Contractor implements clear written policies agreed to in writing by such clinicians to ensure there is no conflict of interest between such individual and any provider requesting authorization or any other actual or potential conflict of interest.

Q.1.6. The Contractor shall obtain provider network data from the Department or one or more of its other designated contractors and shall build and maintain a provider file as specified in the "Information Systems" Section.

Q.2. Access to Provider Files

Q.2.1. Throughout the term of the Contract the Contractor shall:

Q.2.1.1. Ensure that Contractor's staff have immediate access to all provider files through the integrated management information system to allow staff to search for a provider appropriate to a member's needs, preferences, and location.

Q.2.1.2. Ensure that Contractor's clinical staff and Member/Provider Services staff, both in the Service Center and in the field, have wireless, real-time access to the provider file via their computers.

Q.3. Provider Search Function

Q.3.1. The Contractor shall ensure that the Provider Search Function in the Contractor's MIS allows the Contractor staff to conduct provider searches including but not limited to any combination of the following criteria:

Q.3.1.1. Provider type.

Q.3.1.2. Service type/level of care.

Q.3.1.3. Zip Code.

Q.3.1.4. Language.

Q.3.1.5. Gender.

Q.3.1.6. Race/Ethnicity of Provider (when available).

Q.3.1.7. Specialty, using the CMAP provider specialties

Q.3.1.8. Provider Last Name.

Q.3.1.9. Provider First Name.

Q.3.1.10. Provider Medicaid Number; Provider Number.

Q.3.1.11. Whether the provider is accepting new patients.

Q.4. Network Assessment

Q.4.1. The Contractor shall assess the size and scope of providers enrolled in HUSKY Health to assist the Department in determining the need for provider recruitment.

Q.4.2. The Contractor shall:

Q.4.2.1. Send data verification forms, within 30 days of implementation, to all HUSKY Health enrolled providers, requesting among other things, identification of their clinical specialties.

Q.4.2.2. Establish and update provider file information with respect to whether providers are accepting referrals for HUSKY Health members as new patients.

Q.4.2.3. Load the provider and utilization data into the Contractor's MIS, perform a gap analysis and generate a density report to determine network inadequacies based on the standards that will be set forth in the contract that results from the RFP. If the gap analysis performed during implementation indicates a need for additional providers, the Contractor shall outreach to those providers to facilitate enrollment.

Q.4.3. The Contractor shall outreach to the Department's record of HUSKY network providers who have not re-enrolled or who have terminated their enrollment.

Q.4.3.1. Perform a gap analysis regularly (Geo Access study) and density report at least quarterly including only those providers who are accepting new patients. Focus on priority areas as determined by the Department and Contractor's advisory committees.

Q.4.3.2. Priority areas include language capacity, specialty services and appointment times.

Q.4.3.3. Implement ongoing provider monitoring processes to assure network PCPs adhere to timely scheduling of appointments through the Department defined methodology for random appointment call/audit.

Q.4.3.4. Work with PCP practices to offer expanded hours (i.e. evenings, weekends) and telehealth capabilities in contexts in which applicable HUSKY Health services are covered when delivered via telehealth within specified Department requirements. Evaluate the utilization and effectiveness of 24/7 nurse line services or 24 hour physician line services.

Q.4.4. Throughout the term of the Contract, the Contractor shall identify service gaps in a variety of other ways using a variety of data sources including:

Q.4.4.1. Tracking and trending information on member complaints and services requested but not available.

Q.4.4.2. Requesting the Contractor's advisory committees to identify services that are needed but unavailable.

Q.4.4.3. Monitoring services for which authorization is continued for administrative reasons (e.g., lack of essential aftercare services). Monitoring penetration rates by age, location and race/ethnicity.

Q.4.4.4. Monitoring consumer-reported satisfaction with access to services.

Q.4.4.5. Monitoring shifts in numbers of HUSKY Health members in various geographic areas of the state.

Q.5. Network Development

Q.5.1. The Contractor shall assist the Department in addressing deficiencies in the HUSKY Health Provider Network by developing the provider network in geographic areas that do not provide adequate access to sufficient providers in a range of types and specialties to support adequate access to covered services. Specifically, the Contractor shall:

Q.5.1.1. Encourage the use of provider outreach activities, such as scheduled office visits, recruiting and information stations at professional meetings, sponsoring of evidence-based continuing education activities.

Q.5.1.2. Offer clinical or other training at no additional charge to the Department or to the providers-this may include technical assistance including prior authorizations, etc. EMRs are the property of the provider and the Contractor does not have the responsibility to change, modify, or enhance the functionality of such systems. Technical assistance is limited in scope as determined by the Department.

Q.5.1.3. Work with trade organizations and licensing boards to actively recruit providers.

Q.5.1.4. Work with existing HUSKY Health providers to expand existing capacity and add new covered services. Identify potential providers and provide them with information and technical assistance regarding the provider enrollment process and provider service and performance standards to support enrollment in HUSKY Health.

Q.5.1.5. Coordinate with the Department's MMIS Contractor and the Department as necessary to facilitate enrollment of new providers, identify impediments to enrollment, and develop new services for providers already enrolled in HUSKY Health.

Q.6. Critical Access and Single Case Agreements

Q.6.1. In situations where the provider does not enroll, the Contractor shall assist with the facilitation of such enrollment. If after such efforts the provider does not enroll, then the Contractor shall facilitate the execution of special service agreements between a provider and the Department on a case-by-case basis to address critical access issues.

Q.6.2. The terms of such agreements may be negotiated without the participation of the Department, but the final terms of the agreement shall be subject to approval by the Department.

Q.6.3. Such agreements shall be entered into to address access issues including, but not limited to:

Q.6.3.1. Provision of a service that is covered, but not provided by any enrolled provider or in the member's geographic area, or provided out of state when the service is not performed by a Connecticut provider.

Q.6.3.2. Provision of a service to eligible members who are temporarily out-of-state as required pursuant to 42 CFR 431.52 and in need of services.

Q.6.4. The Contractor shall coordinate with the Department and its MMIS Contractor to enroll providers with whom a special service agreement has been negotiated that will be payable through the MMIS.

Q.7. Payment Related Troubleshooting and Technical Assistance

Q.7.1. The Contractor shall facilitate the identification and resolution of provider payment problems. The Contractor shall:

Q.7.1.1. Attend regular meetings hosted by the Department and attended by the Department's MMIS Contractor to address operational issues that are or may impact providers.

Q.7.1.2. Use overall and provider specific payment monitoring reports in coordination with the Department's MMIS Contractor to identify payment problems and diagnose the nature of those problems (i.e., authorization related vs. claims adjudication related).

Q.7.1.3. Participate in a rapid response team consisting of the Department's MMIS Contractor personnel and Contractor personnel to resolve issues related to timely and accurate claims payment.

Q.7.2. The Contractor shall, by April 1, 2022, present to the Department for its review and approval, a plan for coordinating problem assessment and intervention.

Q.7.3. The plan shall include provisions for on-site assistance by a rapid response team when problems persist for more than sixty (60) days.

Q.8. To submit a responsive proposal, the Respondent shall:

Q.8.1. Propose a plan for building and maintaining a provider file with recommended minimum data elements and demonstrate the utility of the system and ease of access to provider file data by the Utilization Management, Intensive Care Management, and Member Services units.

Q.8.2. Propose how the provider database would identify where the services reside by location, provider type, and specialty.

Q.8.3. Propose a plan for the recruitment and retention of providers to address network deficiencies, with emphasis on adequate access to primary care providers and to a complete range of specialist types.

Q.8.4. Propose a plan to support expanded client access to care, including but not limited to identification of providers that are accepting new patients, offering expanded hours (i.e.

evenings, weekends), and offer other services of importance to special populations (cultural competence, special expertise in caring for specific clinical conditions).

Q.8.5. Propose approaches, in addition to those described in Q.7.1.2., to identify and resolve provider authorization.

Q.8.6. Propose a reporting format to support monitoring of network development, including standardize reports access reports with only providers that are accepting new patients.

Q.8.7. Propose a plan for providing technical assistance and support to providers interested in becoming person centered medical home practices and PCMH+ participating entities.

Q.8.8. Propose operational procedures for the payment of providers under special service agreements, through the Department's MMIS.

R. MEMBER SERVICES

R.1. General Requirements

R.1.1. Upon meeting eligibility requirements and enrollment into the Husky Health Program, the Contractor shall issue a member welcome packet which includes a Husky member card. This card is to be compliant with Husky Health Program standards and contain the appropriate logos and identification numbers as required by the Department. The welcome packet introduces the member to the Husky Health Program and contains a description of the Husky Health benefit including services available for medical, behavioral health, dental, and non-emergency medical transportation.

R.1.2. Throughout the term of the Contract, the Contractor's member services staff shall provide non-clinical information to members and when appropriate provide immediate access to clinical staff for care related assistance.

R.1.3. The Contractor shall ensure that member information is clearly communicated in a manner that is culturally sensitive and language appropriate and should supply sufficient information that enables members to make informed decisions to access health services.

> R.1.3.1 The Contractor shall ensure that all written materials are written in plain language, that is, language that may be comprehended by readers at all literacy levels. The Contractor shall accomplish this by ensuring that written information is organized and presented in ways that make it easy for its intended readers to understand and use. The Contractor shall use nationally recognized health literacy resources such as the "Toolkit for Making Written Material Clear and Effective", issued by the Centers for Medicare & Medicaid Services.

R.1.4. Throughout the term of the contract, the Contractor shall ensure that all member services staff shall demonstrate professionalism, respect, and communicate in a culturally appropriate manner with members.

R.1.5. The Contractor shall staff member services with competent, diverse professionals including Spanish-speaking individuals to best serve the needs of members.

R.1.6. The Contractor shall ensure that TDD/TTY and/or video relay services including language translation services are available for those individuals who require them to fully access and take advantage of all services provided by the Contractor.

R.1.7. The Contractor shall identify a “Key Person” responsible for the performance of the Member Services unit.

R.1.8. The Contractor shall develop and implement a formal training program and curriculum for staff that respond to member inquiries.

R.1.9. The training program shall include training in how to recognize members that may need ICM and to make referrals as appropriate.

R.1.10. The Contractor shall develop a reference manual for member service representatives to use during daily operations.

R.1.11. The Contractor staff shall provide members with information that facilitates access to covered services, including referring to enrolled providers of covered HUSKY Health services, assisting with finding enrolled providers in the member’s geographic area, assisting with scheduling appointments with enrolled providers, helping recruit providers of covered HUSKY Health services if none are available, and general advice about accessing HUSKY Health covered services.

R.1.12. The Contractor shall develop, plan and assist members with information related to community based, free care initiatives and support groups.

R.1.13. The Contractor staff shall respond to member clinical care decision inquiries in a manner that promotes member self-direction and involvement.

R.1.14. The Contractor staff shall initiate a warm transfer for callers who require behavioral or dental services to the appropriate ASO or instruct individuals who are not enrolled how they can apply for medical assistance (e.g., Access Health CT, DSS field offices, 211 information line).

R.1.15. The Contractor shall develop a database of providers as further described in the Provider Network section of this RFP identifying providers with cultural competency and linguistic capabilities; and shall use this information to refer individuals to health services that are culturally and linguistically responsive to the preferences of individuals.

R.1.16. When requested by individuals, the Contractor shall identify participating providers, facilitate access, and assist with appointment scheduling when necessary. The Contractor shall develop a database to support this function as necessary.

<u>R.2. Policies and Procedures</u>

R.2.1. The Contractor shall, no later than January 1, 2022, develop and submit to the Department for their review and approval a Member Inquiry Process to include policies and

procedures for resolving and responding to member inquiries. The policies and procedures shall address the tracking and reporting of the following:

R.2.1.1. Complaints regarding the Contractor's performance.

R.2.1.2. Complaints related to the service delivery system.

R.2.1.3. Complaints related to specific providers.

R.2.1.4. Resolution of complaints not later than thirty (30) days from receipt.

R.2.1.5. Routine, urgent and emergent (crisis) calls.

R.2.1.6. Inquiries regarding the status of any denial, reduction, suspension, or termination of services.

R.2.1.7. Inquiries related to the status of authorization requests.

R.2.1.8. Inquiries regarding member rights and responsibilities including those related to complaints and appeals.

R.2.1.9. Forms and instructions for filing a written complaint.

R.2.1.10. Requests for referral, taking into consideration linguistic and cultural preferences when requested.

R.2.1.11. Request to facilitate access and assist with appointment scheduling when necessary; Requests for coverage information including benefits and eligibility.

R.2.1.12. Inquiries related to community based free care initiatives and support groups.

R.2.1.13. Inquiries regarding information related to the behavioral health or dental ASOs.

R.3. Transportation

R.3.1. Throughout the term of the contract the Contractor, through its member services staff shall facilitate and coordinate access to transportation services. The Contractor shall:

R.3.1.1. Facilitate and coordinate access to transportation services for any Medicaid eligible individual by referring the individual to the appropriate Department transportation services broker.

R.3.1.2. Offer to provide a warm transfer to the transportation broker.

R.3.1.3. Ask the caller to call the Contractor back if problems are encountered in accessing transportation.

R.4. Semi-Annual Community Meetings

R.4.1. The Contractor's staff shall coordinate with staff from the Department in the conduct of semi-annual community meetings. The purpose of the community meetings shall be to share information and feedback with members, family members, advocacy groups and providers.

R.4.2. The community meetings shall be conducted in at least five (5) locations throughout the State, as proposed by the Contractor and approved by the Department.

R.4.3. The first series of community meetings shall be conducted between May 1, 2022 and June 30, 2022 and shall focus on orienting members of the community to the new ASO initiative.

R.4.4. The Contractor shall:

R.4.4.1. Develop agendas with common topics across all regions as well as specific local topics suggested by local stakeholders.

R.4.4.2. Select sites and times that will encourage the largest number of participants.

R.4.4.3. Publicize the event throughout the region and across the State.

R.4.4.4. Arrange for a keynote speaker, panel presentation or focus.

R.4.4.5. Provide a mechanism for all attendees to evaluate the meeting and offer suggestions for future regional committee meetings.

R.5. Member Brochure

R.5.1. The Contractor shall develop an informational member brochure by January 1, 2022 to be written in plain language, using well-established health literacy principles in both English and Spanish. The contents of the brochure shall:

R.5.1.1. Explain benefits for members.

R.5.1.2. Describe how to access providers.

R.5.1.3. Describe how to contact the Contractor for assistance; and Describe member rights and responsibilities, including complaints and appeals/hearings.

R.5.2. The Contractor shall produce, print, and distribute the informational member brochure according to a plan approved by the Department and mail a brochure to any member or provider upon request.

R.5.3. The Contractor shall supply the Department with brochures to be distributed by the Department at the time that eligibility is granted and supply large provider sites with brochures for provider distribution at their sites of service.

R.5.4. The Contractor shall revise and update the brochure as required by the Department but not more often than annually and distribute the revised brochures according to the distribution plan approved by the Department. The Contractor will consider other means of communication including web-based video feeds.

R.5.5 The Contractor shall create a secure member portal to allow members to set up online Husky Health accounts. This will allow members access to their Husky Health healthcare information.

R.6. Member Handbook

R.6.1. The Contractor shall, by April 1, 2022, develop a Member Handbook. The Member Handbook shall include:

R.6.1.1. The benefits available to members.

R.6.1.2. The procedures for accessing services covered under the ASO and related services such as transportation and pharmacy for which services may be accessed through the ASO.

R.6.1.3. Rights and responsibilities, including Notices of Action, appeal, and complaints rights.

R.6.2. The Contractor shall post the Member Handbook on the ASO Website and shall print and mail or otherwise arrange delivery of this handbook to members upon request.

R.6.3. The Contractor's proposal for the ASO Website shall include a member services section and such section shall:

R.6.3.1. Contain information for members and their families concerning health information for members.

R.6.3.2. Ensure that the website has the capability of exchanging ASO information and member information with providers and members.

R.6.3.3. Include the text of the Member Handbook.

R.6.3.4. Include security provisions approved in advance and required by the Department.

R.7. To submit a responsive proposal, the Respondent shall:

R.7.1. Propose and fully describe the staffing needed to adequately address member services inquiries. The description shall include:

R.7.1.1. A flow chart and narrative that describes and justifies the relationship between the member services staff and other on-call staff with clinical expertise and Quality Management staff.

R.7.1.2. A staffing schedule to operate the system as described above.

R.7.2. Provide a description of the decision process that member services staff will use to respond to requests for services and/or information. Recognizing that non-clinical staff will answer some member services phone calls that may require clinical judgement, the Respondent shall fully explain its method to redirect calls to clinical staff.

R.7.3. Provide a description of a member services training program the Respondent has implemented.

R.7.4. Describe the strategy for responding to member access inquiries and complaints, including a description of how complaint related information is captured to support complaint reporting as established in Exhibit E (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents) Include a description of the process for identifying participating providers, facilitating access, and assisting with appointment scheduling when necessary.

R.7.5. Describe the website capabilities available for use including web-based video capabilities.

S. TELEPHONE CALL MANAGEMENT

S.1. General Requirements

S.1.1. Throughout the term of the Contract, the Contractor shall provide Telephone Call Management Services in a manner that facilitates member and provider access to information and services in an efficient, convenient, and user-friendly manner. This shall include the use of both interactive voice response systems (IVR) and staffed lines, the use of industry standard technology to monitor and distribute call volume, and the ability to provide detailed and timely reporting for both day-to-day operational management and ongoing service quality monitoring.

S.1.2. The Contractor shall provide and operate call management services through a location in Connecticut. After hours services, such as crisis triage, may be managed out of state with the Department's advance approval, but must be within the United States.

S.1.3. The Contractor shall include up to three (3) nationwide toll-free lines, one of which shall be dedicated to fax communications.

S.1.4. The Contractor shall develop, implement and maintain operational procedures, manuals, forms, and reports necessary for the smooth operation of the Telephone Call Management Services.

S.2. Line Specifications

S.2.1. The Contractor shall establish and maintain a toll-free telephone line for members and providers with the following specifications:

S.2.1.1. Access to a limited menu interactive voice response (IVR) system. Speech recognition is required.

S.2.1.2. Ability to receive transferred calls from other IVR Systems.

S.2.1.3. Ability to transfer calls to applicable DSS staff and locations, as specified by the Department.

S.2.1.4. Ability to warm transfer to the Department and Department's agents for eligibility/ enrollment, dental, behavioral health, pharmacy, transportation, and claims services.

S.2.1.5. Ability to immediately transfer calls to a direct contact with a service representative on a priority basis without the caller having to listen to IVR menu options.

S.2.1.6. Conferencing capability and web-based meetings with large group capacity.

S.2.1.7. TDD/TTY capability for hearing-impaired.

S.2.1.8. Multi-lingual capabilities.

S.2.1.9. Overflow capability.

S.2.1.10. Voicemail capability.

S.2.2. The Contractor shall establish and maintain the following menu options for members that call the main toll-free telephone line:

S.2.2.1. Crisis Calls. The crisis calls that are received during normal business hours shall be routed to clinical staff. Crisis calls that occur after business hours shall be handled in a manner agreeable to the Department and the Contractor.

S.2.2.2. Member Services. The Member Services Line shall enable members to call with questions, information, and clinical requests during normal business hours.

S.2.3. The Contractor shall establish and maintain the following menu options for providers that call the main toll-free telephone line:

S.2.3.1. Authorization requests twenty-four (24) hours a day and seven (7) days per week.

S.2.3.2. Provider Services during normal business hours.

S.2.3.3. Authorization Verification: This option shall allow a provider to obtain information regarding the status of an authorization request.

S.3. Performance Specifications

S.3.1. Throughout the term of the Contract the Contractor shall meet or exceed the following Performance Specifications for Telephone Call Management or web-based applications. The Contractor shall:

S.3.1.1. Ensure that the IVR system provides the options menu to all callers within two (2) rings.

S.3.1.2. Ensure that the member and provider call-in lines never have a busy signal.

S.3.1.3. During normal business hours, provide sufficient and appropriate staff to answer all IVR transferred crisis calls and answer 100% of such calls within fifteen (15) seconds with a live person, and maintain an abandonment rate of less than 5%.

S.3.1.3.1. When crisis calls are not answered within the first fifteen (15) seconds, the IVR shall initiate a recorded message encouraging a caller to remain on the

line and assuring a caller that a qualified staff person will answer the call momentarily or provide the caller with a callback option that keeps the caller in the call queue and calls them back when an agent is available.

S.3.1.4. After business hours, provide sufficient and appropriate staff to answer all IVR transferred crisis calls and dispatch the caller to a live person with the appropriate mobile crisis team or program the phone system to automatically distribute the caller to the appropriate crisis line, as described above.

S.3.1.5. All crisis calls shall be answered within fifteen (15) seconds or automated phone transfers shall occur within ten (10) seconds.

S.3.1.6. Provide sufficient and appropriate staff to answer all IVR transferred calls from the member services menu and shall answer 90% of calls with a live person within thirty (30) seconds and maintain an abandonment rate under 5% during Normal Business Hours.

S.3.1.7. During non-business hours when a staff person is not available for routine calls, the IVR shall respond with a recording within ten (10) seconds of the IVR call activation, instructing the caller to call back during normal business hours.

S.3.1.8. Produce a monthly report for the Department's review that documents each rerouting incident (including IVR transferred crisis calls) the answer time and the associated reason for the rerouting. This report shall be identified as the Network Call Rerouting (NCR) Report.

S.3.1.9. Provide sufficient and appropriate staff to answer all IVR transferred calls to the Authorization Line twenty-four (24) hours a day, seven (7) days a week for providers, who shall answer 90% of such calls with a live person within (thirty) 30 seconds and maintain an abandonment rate of less than 5%.

S.3.1.9.1. When a staff person is not available, a recording shall respond every thirty (30) seconds instructing the caller to wait for the next available agent or provide the caller with a callback option that keeps the caller in the call queue and calls them back when an agent is available.

S.3.2. Provide sufficient and appropriate staff to answer all IVR transferred calls to Provider Services line who shall answer 90% of calls with a live person within thirty (30) seconds and maintain an abandonment rate under 5% during Normal Business Hours.

S.3.2.1. During non-business hours when a staff person is not available, the IVR shall respond with a recording within ten (10) seconds of the IVR call activation instructing the caller to call back during normal business hours.

S.3.3. Ensure that Contractor's staff and IVR can communicate in English and Spanish on an as needed basis and that access is provided to a language line twenty-four hours a day, seven days a week to serve members.

S.3.4. Ensure that Contractor's telephone staff greets all callers, identify themselves by first name when answering and always treat the caller in a responsive and courteous manner.

S.4. Automatic Call Distribution Reporting

S.4.1. Throughout the term of the Contract the Contractor shall establish and maintain a functioning automatic call distribution (ACD) call reporting system that, at a minimum, has the capacity to record and aggregate the following information by IVR line:

S.4.1.1. Number of incoming calls.

S.4.1.2. Total number of answered calls by Contractor staff.

S.4.1.3. Average number of calls answered by each Contractor staff member.

S.4.1.4. Average call wait time by staff member.

S.4.1.5. Average talk time by staff member.

S.4.1.6. Percent of crisis calls answered by staff in less than fifteen (15) seconds during normal business hours after the selection of a menu option.

S4.1.7. Percent of crisis calls answered by staff in less than fifteen (15) seconds or the systematic transfer within ten (10) seconds during after hours after the selection of a menu option.

S.4.1.8. Percent of routine Member Services calls answered by staff in less than thirty (30) seconds after the selection of a menu option.

S.4.1.9. Percent of provider Authorization calls answered by staff in less than thirty (30) seconds after the selection of a menu option.

S.4.1.10. Percent of Provider Services calls answered by staff in less than thirty (30) seconds after the selection of a menu option.

S.4.1.11. Number of calls placed on hold and length of time on hold.

S.4.1.12. Number and percent of abandoned calls. (For purposes of this section abandonment refers to those calls abandoned thirty (30) seconds after the entire menu selection has been played). The call abandonment rate shall be measured by each hour of the day and averaged for each month.

S.4.2. The Contractor shall maintain phone statistics daily and shall tally and submit the statistics to the Department in accordance with the reporting schedule and format outlined in Exhibit E (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents), Reporting Matrix. The Department reserves the right to change the reporting timeframe for these reports; however, any revised timeframes must be mutually agreed upon by the Department and the Contractor.

S.5. To submit a responsive proposal, the Respondent shall:

S.5.1. Describe and justify the capabilities of the phone system and web-based portal (including text and chat functionality or other available media platforms) to support the requirements of the contract including:

S.5.1.1. The number of phone lines.

S.5.1.2. Number and type of or job classification of staff including experienced staff assigned to the Crisis Line, Member Services Line and Provider Lines by time of day and day of the week.

S.5.1.3. A proposed methodology to monitor the performance specifications listed above in N.3.

S.5.2. Describe the Disaster Recovery Plan including:

S.5.2.1. Plan to respond to phone calls seamlessly in the event of local power failures, phone system failures, or other emergencies.

S.5.2.2. Plan to provide operator response to calls when the number of calls exceeds the anticipated call demand.

S.5.3. Describe a comprehensive inbound and outbound IVR system to be operated within the parameters described above.

S.5.4. Propose a plan to accommodate the cultural and language needs of individuals who call in to the IVR.

S.5.5. Describe training requirements and standards related to Member Services.

S.5.6. Describe proposed staffing ratios to handle the expected volume of calls coming into the Telephone Call Management Center as well as its contingency plan for when its staffing cannot fully support the call volume as identified by its staffing ratios.

S.5.7 Describe back up operations (including off site) for all systems including website, web portals (including provider web-based authorization portals. Also describe off site capability of staff to maintain the program and the ability to retrieve data/information should a local disaster occur.

T. DATA AND REPORTING REQUIREMENTS

T.1. General Requirements

T.1.1. The Contractor shall store all operational data collected in an information system that is compliant with Open Database Connectivity Standards (ODBC) or current industry standard and allow for easy data capture. *To meet data protection the* Contractor *shall ensure all data at rest and in transit is encrypted to meet FIPS 140-2*.

T.1.2. The Contractor shall ensure that the information system's reporting capacity is flexible and able to use data elements from different functions or processes as required to meet the program reporting specifications described in the contract resulting from this RFP.

T.1.3. The Contractor shall provide the Department with a mutually agreeable electronic or Web-based file format of the MIS data dictionary of all data elements in all databases maintained in association with the contract resulting from this RFP.

T.1.4. The Contractor shall ensure that any database used in association with the contract resulting from this RFP can execute ANSI SQL or current methodology.

T.1.5. The Contractor shall respond to questions or issues regarding data and/or reports presented to the Contractor within five (5) business days unless otherwise specified.

T.1.6. The Contractor shall provide access to detailed and summary information that the Contractor maintains regarding UM decisions, information on other registration services, UM staff coverage, appeals and complaints, and related data in conjunction with the authorization process.

T.1.7. The Contractor shall collect and maintain data from external sources, including but not limited to, ADT feeds and HIEs, as necessary for care coordination and the administration of m services, and as directed by the Department. The Contractor shall make all such information available in a nonproprietary format to the Department and any contractors or third parties designated by the Department to receive such information.

T.2. Report Production, Integrity and Timeliness

T.2.1. The Contractor shall establish and notify the Department of the "Key Person" responsible for the coordination of the transmission of reports, correction of errors associated with the reports, as well as the resolution of any follow up questions. A protocol must be in place should a "key person" not be available and an urgent matter needs to be resolved immediately.

T.2.2. The Contractor shall be required to submit to the Department certain reports regarding the Contractor's activities.

T.2.3. The Contractor shall track report requests and work hours expended to satisfy the request.

T.2.4. The Contractor shall comply with requests from the Department to modify or add to the reporting requirements set forth herein unless the Contractor demonstrates to the Department that to meet such requirements, there must be a modification to the functional design of the information systems or increased staffing which will result in additional costs to the Contractor.

T.2.5. The Contractor shall provide the Department on or before January 1, 2022, for its review and approval the processes and controls implemented by the Contractor to ensure "data integrity", defined as the ability to ensure data presented in reports are accurate (e.g. "reporting accuracy").

T.2.6. Be required to submit to the Department certain reports regarding the Contractor's activities.

T.2.7. The Contractor shall be responsible for the production of all HEDIS designated reports as well as hybrid HEDIS reports currently listed in Exhibit E (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents) Reporting Matrix or those to be developed including the use of HEDIS certified software and independent audit requirements.

T.2.8. Whenever the due date for any report falls on a day other than a Business Day, such due date shall be the first Business Day following such day.

T.2.9. The Contractor and the Department agree that the parties may desire to change Exhibit E, Reporting Matrix. Such changes may include the addition of new reports, the deletion of existing reports and/or changes to due dates, prescribed formats and medium. The Department will work closely with the Contractor on all reporting requirements, but the Department has final decision-making authority as to the type and structure of all reports.

T.2.10. The Contractor and the Department may agree to change Exhibit E (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents). However, such change shall only be effective as of the date that the Department and the Contractor agree, in writing, to the change.

T.2.11. The Contractor shall not be held liable for the failure to comply with a reporting requirement set forth in Exhibit E (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents), as changed by agreement of the parties from time to time, in the event that the Contractor's failure is a result of the Department's failure to provide the necessary data and/or data extracts.

T.2.12. The Contractor shall produce all reports accurately with minimal revisions following submission.

T.2.13. The Contractor shall advise the Department, within one (1) business day, when the Contractor identifies an error in a line item of a report and submit a corrected report within five (5) business days of becoming aware of the error.

T.2.14. The Contractor shall specify on the corrected report the element that changed, the cause of the error and the guidelines that the Contractor shall implement to prevent future occurrences.

T.2.15. If it is apparent that the submission date for a report will not be met, the Contractor shall request in writing an extension for submission. Such request must be received by the Department no later than one (1) business day before the scheduled due date of the report. The Department, based on circumstance, will decide if such extension will or will not be granted.

T.3. Data Storage and Elements

T.3.1. In addition to the data elements necessary to complete the reports in Exhibit E (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents) and as described in the "Utilization Management" and "Quality Management" Sections, the Contractor shall store data with report programming flexibility to produce, sort and summarize reports that include one or more of the following data elements:

T.3.1.1. ImpaCT Unique Client Identifier.

T.3.1.2. Age (including summarization by age bands and or focus on a specific age, including those age bands specified in Exhibit E) (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents).

T.3.1.3. Gender.

T.3.1.4. Diagnoses.

T.3.1.5. Significant co-morbidities, including pregnancy.

T.3.1.6. ICM Indicators.

T.3.1.7. BHP ICM co-management.

T.3.1.8. Local areas as defined by the Department.

T.3.1.9. Program (HUSKY A, HUSKY B, HUSKY C, HUSKY D, and each of the Medicaid limited benefit plans) and additional special population identifier, if any.

T.3.1.10. PCP assignment.

T.3.1.11. PCMH attribution and, if applicable for the individual, PCMH+ assignment.

T.3.1.12. ICO attribution.

T.3.1.13. Waiver/MFP enrollment.

T.3.1.14. Court involvement/mandate type.

T.3.1.15. DCF identifier, if applicable.

T.3.1.16. Ethnicity and Race.

T.3.1.17. MMIS provider type.

T.3.1.18. MMIS provider specialty.

T.3.1.19. Provider identifiers and TIN.

T.3.1.20. Service type/level of care.

T.3.1.21. Procedure code/revenue code.

T.3.1.22. Fiscal Year or Calendar Year.

T.3.1.23. Periodic Comparison (month to month, year to year).

T.3.1.24. Compilation by day, week, month, quarter, semiannually, and yearly.

T.4. Data Aggregation

T.4.1. The Contractor shall aggregate the data collected statewide by standard human service regions provided by the Department or by zip code.

T.4.2. The Contractor shall aggregate the data collected geographically by client's town of residence and provider service location. Geographic aggregation of provider data shall be based upon the provider's type, specialty and service location.

T.4.3. The Contractor shall aggregate data collected by client/medical home attribution; client attribution; or client/integrated care organization attribution as such attribution methodologies are established.

T.4.4. The Contractor shall ensure that authorization data includes units denied and authorized.

T.5. Standard and Ad-hoc Reports

T.5.1. As requested by the Department, the Contractor shall produce for the Department Standard and Ad-hoc reports, including those that may be required or requested of the Department (e.g., by the legislature, the Council on Medical Assistance Program Oversight established pursuant to section 17b-28 of the Connecticut General Statutes and more commonly known by its former acronym of MAPOC, OPM, CMS, or other applicable agency or entity).

T.5.2. The Contractor shall produce Standard reports on a regularly scheduled basis as defined by the Department on all activities and measures in the format outlined in the Data Reporting Requirements section and Exhibit E (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents), Reporting Matrix. The Department may modify the format and specifications of these Standard reports.

T.5.3. The Contractor shall produce Ad-hoc reports upon request of the Department. Ad-hoc reports may require data from any or all the Contractor's databases associated with the contract resulting from this RFP including but not limited to the provider database, authorization database and credentialing database. The Contractor shall provide a request form that structures the Ad-hoc report request process such as by identifying report criteria, data necessary, priority, resources, and turnaround time. If the Department and the Contractor mutually agree that the requested report exceeds staff resources, the Contractor shall work with the Department to prioritize requests to accommodate requested reports within available resources. If requested reports cannot be so accommodated, the Contractor and the Department shall negotiate the cost of accommodating the request based on limitations and available resources.

T.5.4. The Contractor shall produce and deliver such Ad-hoc reports to the Department within five (5) business days of the Contractor's receipt of the Department's written request. If the Contractor will not be able to make the Ad-hoc report available within the requisite five (5) business days, then the Contractor shall, within three (3) business days from its receipt of the initial request, notify the Department's that of the estimated production date. The Contractor's response shall include reporting specifications, report development and resource requirements, and the expected delivery date of the information.

T.6. To submit a responsive proposal, the Respondent shall:

T.6.1. Provide a description of the proposed information system and its ability to meet the requirements of this section.

T.6.2. The Department's MMIS claims data will be used to undertake HEDIS reporting. Describe in detail the plan for using the Department's claims data to produce all required HEDIS reports. Identify any challenges that may be associated with the use of Department provided claims data to produce all HEDIS reports and any proposed resolution.

T.6.3. Identify the steps that will be undertaken to ensure that the integrity of the data is maintained within the information system and to assure the quality and integrity of reports that will be produced under the resulting Contract.

T.6.4. Provide additional sample and/or de-identified reports that have been utilized by the Respondent in the management of similar populations.

U. INFORMATION SYSTEM

U.1. System Requirements

U.1.1. The Contractor shall be required to transmit authorization data to the Department MMIS Contractor, integrate claims and authorization data and to produce extracts for the Department data warehouse.

U.1.2. The Contractor shall establish and maintain HIPAA compliant computer systems to accommodate all operational and reporting functions set forth herein.

U.1.3. The Contractor shall establish and maintain connectivity between the Contractor's information system and the Department's systems and to support the required eligibility data exchanges based upon the Department's standards for the exchange of data.

U.2. Eligibility Data

U.2.1. The Contractor shall accept eligibility data from the Department and the Department's contractors and partners electronically.

U.2.2. Upon receipt of the eligibility data from the Department and/or its contractors, the Contractor shall conduct a quality assurance or data integrity check of the eligibility data.

U.2.2.1. Any eligibility audit report that results in an error rate below two percent shall be loaded into the Contractor's information system within two business days of receipt.

U.2.3. The Contractor shall, in a format specified by the Department, notify the Department of any eligibility record that errors out due to missing or incorrect data and post corrected data to the Contractor's eligibility system.

U.2.4. The Contractor shall generate an update report that includes the number of eligibility records that have been read and the percentage of records loaded.

U.2.5. The Contractor shall provide all authorized Intensive Care Managers with on-line access to the Contractor's comprehensive eligibility database to serve members and providers.

U.2.6. The Contractor shall verify the eligibility of persons not yet showing in the monthly eligibility file utilizing PC-based software, Provider Electronic Solutions (PES), to query the Department's Automated Eligibility Verification System (AEVS).

U.2.7. The Contractor shall add a missing member to the Contractor's eligibility database as a "temporary" member if services are requested by or for an individual who is not listed on the monthly eligibility file but who is listed on AEVS.

U.3 Social Security Administration

U.3.1. If the Contractor accesses, uses, discloses, processes, handles, or transmits data provided by the Social Security Administration (SSA), then the Contractor must comply with all the terms and conditions of this subsection of the Agreement.

U.3.2. The Contractor acknowledges that it has received a copy of the Department's Information Exchange Agreements (IEAs), and related attachments.

U.3.3. The Contractor shall abide by all relevant Federal and state laws and restrictions on access, use, and disclosure of SSA-provided data.

U.3.4. The Contractor shall abide by the security requirements contained in the Department's IEAs with the SSA.

U.3.5. The Contractor acknowledges that use of SSA-provided data not authorized by the Department's IEAs or this Agreement may be subject to both civil and criminal penalties under Federal law.

U.3.6. The Contractor shall treat all SSA-provided data as confidential and shall access, use, and disclose SSA-provided data only for purposes authorized in this in the IEAs and this Agreement, and as permitted under Federal and state law.

U.3.7. Prior to obtaining access to SSA-provided data, and thereafter at any time requested by the SSA or DSS, the Contractor shall provide DSS with a list of all employees and agents who will require access to the SSA-provided data.

U.3.8. Any employee or agent of the Contractor who will use, access, disclose, process, handle, or transmit data provided by the SSA data shall sign the Department's W-1077C Confidentiality and Non-Disclosure Agreement for Contractor Employees prior to obtaining access to any SSA-provided data.

U.3.9. Any employee or agent of the Contractor who will use, access, disclose, process, handle, or transmit SSA-provided data shall take initial security awareness training prior to obtaining access to SSA-provided data, and shall take training annually thereafter. The training shall be administered by the Department through a web-based portal. Failure to complete the security awareness training will result in denial or termination of access to the SSA-provided data and related Department systems.

U.3.10. The Contractor shall be subject to security compliance reviews, in conformity with SSA standards, at minimum every three years. The Contractor shall comply with Department and SSA requests for documentation related to security compliance.

U.3.11. If the Contractor processes, handles, or transmits data provided to DSS by the SSA or has authority to act on DSS's behalf, then the Contractor additionally must comply with all the terms and conditions of this subsection of the Agreement:

U.3.12. The Contractor agrees to follow the terms of the Department's IEAs with SSA.

U.3.13. The Contractor agrees that the Department or the SSA may perform onsite reviews to ensure compliance with the following SSA requirements:

U.3.13.1. Safeguards of sensitive information.

U.3.13.2. Computer system safeguards.

U.3.13.3. Security controls and measures to prevent, detect.

U.3.13.4. resolve unauthorized access to, use of, and disclosure of SSA-provided information.

U.3.13.5. Continuous monitoring of the Contractor's or agent's network infrastructures and assets.

U.4 Security or Data Privacy

U.4.1 During the annual policy and procedure review the Contractor shall provide the Department the most recent 3rd party Information Security or Data Privacy compliance assessment report completed over the past year.

U.5. Build and Maintain the Provider File

U.5.1. Initial Provider File Information and Updates

U.5.1.1. The Contractor shall receive an initial provider extract from the Department's MMIS Contractor in a file layout and media determined by Department's MMIS and load the information into the Contractor's MIS.

U.5.1.2. The Contractor shall accept from the Department's MMIS Contractor provider adds and changes to the Contractor at a frequency agreeable to the Contractor and the Department in a format and media determined by the Department and update the Contractor's MIS provider file accordingly within three (3) business days of receipt.

U.5.1.3. The Contractor shall accept from the Department additional source provider data that it may otherwise obtain from providers and use such information to build a more comprehensive provider file.

U.5.1.4. The Contractor shall build the provider file locally and such file shall reside on a server located in its Connecticut Service Center, unless the Contractor is able to satisfy the Department that it can comply with all of the requirements with a provider file that does not reside locally.

U.5.2. Supplemental Information

U.5.2.1. The Contractor shall customize the Contractor's MIS provider file to accommodate supplemental information required by the Department.

U.5.2.2. The Contractor shall update the Contractor's provider file to include the supplemental data elements obtained through the provider re-enrollment process and the uniform provider application developed by the Department.

U.5.3. Provider Identification

U.5.3.1. The Contractor shall propose and implement a provider identification solution in its provider file that shall permit all authorizations to be correctly linked to the provider's CMAP ID, provider type and specialty and that will enable reporting and external provider searches by service location (address) regardless of provider type.

U.5.3.2. The Contractor shall utilize the provider's NPI, assignment type, provider type and specialty in the authorization or denial of services. This will enable reporting and external provider searches by service location (address) regardless of provider type.

U.5.4. Data Elements

U.5.4.1. The Contractor shall store the minimum provider data elements as required by current system configuration and the minimum provider data elements in the table below in the Contractor's MIS provider file.

Data Elements	
Provider Type	Clinical Specialties
Service Types	Discipline License Level
Provider ID	Provider Specialty

Location ID	Primary service location address
CMAP ID	Alternate service location address
CMAP Provider type	Service City (Primary and alternates)
CMAP Provider specialty	Service State (Primary and alternates)
Last Name	Service Zip (Primary and alternates)
First Name	Service Phone (Primary and alternates)
Middle Initial	Service Contact Name

U.6. Health Information Technology

U.6.1. The Contractor shall adhere to all applicable federal and state standards, as updated and amended from time to time, regarding use of technology to transmit, receive, maintain, handle and process electronic information. Such standards include, but are not limited to, the Health Insurance Portability and Accountability Act, the HITECH Act, and the Centers for Medicare & Medicaid and the Office of National Coordinator Interoperability and Patient Access Rule.

U.6.1.2 The Contractor shall comply with any health information technology standards specified by the Department.

U.7. To submit a responsive proposal, the Respondent shall:

U.7.1. Describe how technology architecture streamlines the transfer of data from both internal and external sources.

U.7.2. Describe how accurate eligibility files and process updates will be maintained in a timely manner.

U.7.3. Describe how accurate provider files, provider updates, and information obtained from external sources into the provider platform will be maintained in a timely manner.

U.7.4. Describe the architecture of its current IT and operational systems.

U 7.5. Provide documentation of current IT assets (including any cloud-based services) and data, including any contracts for such services.

U.7.6. Propose an approach to transitioning from its current IT systems to future modular solutions such as Connecticut Medicaid Enterprise Technology System (https://portal.ct.gov/DSS/CT-METS). This approach must at a minimum:

U.7.6.1. Identify risks and possible mitigations or other response strategies to minimize adverse impacts.

U.7.6.2. Provide a strategy to maximize operational alignment with MITA-defined business processes.

U.7.6.3. Provide a strategy for use of common solutions to support business processes.

U.7.6.4. Provide a strategy for aligning with and conforming to applicable CMS and Medicaid enterprise-standards, including applicable security and architectural standards.

U.7.6.5. Describe the alignment with the proposed Information Services budget.

V. HEALTH EQUITY

V.1. Health Equity Quality Improvement

The Contractor is responsible for creating conditions in which all members can attain their highest possible level of health without limits imposed by structural inequities. The Contractor shall ensure that services are equitable to underserved, socially disadvantaged, and ethnically diverse groups which include services that are culturally and linguistically appropriate. In this regard, the Contractor is required to collect data on race, ethnicity, geographic area, sex, primary language, and disability, to the extent practicable, and to submit to the Department an annual report on quality improvement activities accomplished through the use of either a) demographic data tracking health disparities with corrective actions as needed, b) a cultural and linguistic competence-related measure with corrective actions as needed, c) program improvement activities addressing the social/environmental determinants of health, and d) a consumer satisfaction survey (highlighting race, ethnic, sex, geographic area, Primary language, and disability breakdowns) with corrective actions as needed.

V.2 Health Equity Strategies

The Contractor shall incorporate in all work products the following health equity strategies:

V.2.1. Attention to social determinants of health and language accessibility

V.2.2. Focus on communities that have experienced major obstacles to health

V.2.3. Promotion of equal opportunities for all people to be healthy and to seek the highest level of health possible.

V.2.4. Continuous efforts to involve consumer voices to advocate for health equity after eliminating avoidable health inequities and health disparities.

V. 3. To submit a responsive proposal, the Respondent shall:

V.3.1. Submit a disparity impact statement. This statement must include:

V.3.2. Example subpopulation categories include race/ethnicity, gender, and sexual orientation/identity status.

V.3.3. A plan for how data will be used to monitor disparities and implement strategies to improve access, service use, and outcomes.

V.3.4. Describe the details of how a health equity project that was developed, implemented, and managed, and the outcomes and impact of the project on the intended target population.

V.3.5. Describe the Respondent's overall qualifications and background to carry out a project of this nature and scope. This should include and highlight its experience with Consumer Engagement and hard to reach communities.

V.3.6. Describe the Respondent's content level knowledge relevant to the importance of Health Equity, including frameworks or methods used to address health equity in health care.

V.3.7. Describe contracts held within the past five years with a scope like (or more substantial than) this RFP. What did you learn from your successes and failures that you would apply to health equity?

V.3.8. Provide two (2) work samples of your organization's framework for consumer engagement, and specifically, engagement with marginalized non-English speaking communities.

W. ATTACHMENTS

W.1: The link below is the health population and risk score, health care cost and utilization (category of expense), inpatient and readmission, emergency department utilization, births, and high cost population breakout.
https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents

W.2: The below link is a breakout of medical authorization requests by service type.
https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents

W.3: The below link is a breakout of providers by provider type and specialty. Providers are identified in the MMIS using this classification for purposes of payment, prior authorization, and reporting.
https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents

3. COST PROPOSAL

A. Financial Requirements.

To submit a responsive proposal, The Respondent shall:

A.1.Audited Financial Statements

Submit one (1) copy of the Respondent's two (2) most recent annual financial statements prepared by an independent Certified Public Accountant and reviewed or audited in accordance with Generally Accepted Accounting Principles (GAAP). The copies shall include all applicable financial statements, auditor's reports, management letters, and any corresponding reissued components.

A.2. Financial Policies and Procedures

Include Respondent's financial policies and procedures. All State agencies entering into contracts, grants, or other agreements with organizations that receive funding from the State of Connecticut must implement the provisions of cost standards. More information about the cost standards is available on OPM's web site: Cost Standards. The Respondent's Cost Allocation Plan, as specified in the Cost Standards, should be included in the Financial Policies and Procedures.

A.3. Financial Capacity

Describe the Respondent's financial capacity to properly isolate contract-related income and expenditures. Discuss the internal controls used to ensure that a thorough record of expenditures can be provided for purposes of an audit.

B. Budget Requirements

B.1 Budget Form

B.1.1.The Respondent shall provide the budget using the Budget Form, embedded as a hyperlink (Exhibit F) (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents). The budget form shall include line items for all expenses to be incurred through the delivery of services and formulas shall not be altered. Bidders may insert rows within Section 1) Personnel and Fringe, if additional staffing is needed.

B.2. Budget Reporting Instructions

Complete only the cells with blue font. Black font indicates a calculation.

The budget should include a transition/Startup Budget for the period of January 1, 2022 through June 30, 2022, if applicable. The Start-Up period should be reported in Columns B and C. The annual budget for Years 1 through 3 covers the period of July 1, 2022-June 30, 2025 and includes the annual operational budgets and detailed salaries, wages, and fringe benefits.

Section 1: Personnel and Fringe
Enter full time equivalents (FTEs) and salaries incurred by the Contractor solely for the operation of the Connecticut Service Center.

The total fringe benefits shall not exceed 21.5% of total salaries without the prior written approval of the Department.

Salaries and Fringe expenses are limited to expenses incurred by full or part-time staff, whose time is either 100% on-site in Connecticut or out-of-state call center staff, who provide services related to the Connecticut contract after normal business hours.

The Corporate Allocation should apply to expenditures related to indirect services (e.g., Corporate functions such as Human Resources, Payroll, Accounting, etc.). Corporate Allocation shall not exceed 10% of the sub-total budget without Corporate Allocation. The Respondent's total corporate allocation costs shall not exceed 10% of the total funding request per contract year and the total anticipated contract period. In addition, the resultant Contractor's total corporate allocation costs shall not exceed 10% of the quarterly expenditures reported. The total funding request for the Startup/Transition period and each contract year shall include 5% Performance Pool, which will be held until earned through meeting the requirements of the agreed upon performance targets. (Exhibit A) (https://portal.ct.gov/DSS/Fiscal/RFP-Links/Medical-ASO-RFP-Documents)

Section 2: Other Direct Expenses
Other Direct costs are limited to those expenses incurred by the Contractor using services, equipment and supplies purchased or contracted for by the Contractor solely for the provision of Connecticut contract services.

Section 3: Total Costs
This section reflects the calculation of the total Personnel and Fringe plus the total Other Direct Expenses. This section is formula-driven and should not be altered.

Section 4: Total Contract
Total Performance Pool is based on a fixed percentage of the Pre-Profit Subtotal. This section is formula-driven and should not be altered.

B.3. Budget Narrative

The narrative shall describe how the funds shall be spent and detail each line-item budget including, but not limited to a brief explanation of each staff position, the number of hours worked and hourly rates.

Note: If subcontractors are used, provide the above narratives for each subcontractor.

B.4. **To submit a responsive proposal, The Respondent shall:**

B.4.1. Provide a completed budget using the link provided and as per the instructions above.

B.4.2. Provide a detailed budget narrative, including for subcontractors, if applicable.