
**REQUEST FOR INFORMATION
FOR BEHAVIORAL HEALTH PROGRAM**



**STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
55 ELM STREET
HARTFORD, CT 06106-1775**

SECTION I

INTRODUCTION AND BACKGROUND INFORMATION

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY. This RFI is issued by the Office of the State Comptroller (OSC) solely for information and planning purposes. It does not constitute a Request for Proposal (RFP) or a promise to issue an RFP in the future. This request for information does not commit the OSC to contract for any service whatsoever. Further, OSC is not at this time seeking proposals and will not accept unsolicited proposals. Responders are advised that OSC will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI will not preclude participation in any future RFP that may be issued for these services. However, the State reserves the right to preclude any vendor who does not respond to this request from participating in any future RFP that may be issued for these services.

A. BACKGROUND

The State of Connecticut Health Plan (Plan) is a self-funded governmental health benefit Plan that is not subject to the Employee Retirement Income Security Act ("ERISA"). The State has contracted with two insurance carriers, Anthem Blue Cross and Blue Shield (Anthem) and UnitedHealthcare/Oxford (UHC), on an Administrative Services Only (ASO) basis to access their provider networks and provide claims management, adjudication and administrative services. Care Management Solutions, Inc. (CMSI), an affiliate of ConnectiCare Insurance Company, monitors members' compliance with the Health Enhancement Plan (HEP) requirements (see below) and provides disease and care management services to Members with chronic conditions. The OSC is located in Hartford, Connecticut.

The Plan currently covers approximately 105,300 subscribers (55,000 active, 300 self-pay, and 50,000 retirees, of whom 15,000 are under age 65 and 35,000 are Medicare-eligible), as well as their dependents, located primarily in Connecticut. Approximately 221,000 state employee-affiliated lives are currently covered in total. OSC provides a continuation of the same hospital-medical plan options for Medicare-eligible retirees and Medicare-eligible dependents secondary to Medicare Parts A and B. In addition, the State allows other Connecticut municipalities to access the UHC plans through a Partnership arrangement; there are currently approximately 4,000 subscribers representing 10,000 lives who obtain benefits through the State. While the plan provisions are subject to some interpretation, changes in benefits are generally subject to collective bargaining.

For the purpose of preparing responses to this RFI for the State of Connecticut Health Plan, the data Exhibits exclude the State’s Medicare-eligible retirees in the Anthem and UHC plans, as well as the claims and lives data for those who are covered through the Partnership arrangement. However, your Fee Information should take into account these additional participants.

Anthem and UHC both offer Point of Service (POS), Point of Enrollment (POE) and Point of Enrollment-Gatekeeper (POE-G) plans. There are also Out-of-Area plans under both vendors. The following provides high-level descriptions of the options available under both Anthem and UHC:

- Point of Service Plans (POS)—health care services are available both within and outside a defined network of providers; no referrals are necessary to receive care from participating providers. Health care services obtained outside the defined network may require pre-authorization and are reimbursed at the rate of 80% of the plan allowable cost after the annual deductible has been met.
- Point of Enrollment Plans (POE)—health care services are available only from a defined network of providers; no referrals are necessary to receive care from participating providers; health care services obtained outside the defined network may not be covered.
- Point of Enrollment Gatekeeper Plans (POE-G)—health care services are available only from a defined network of providers; a primary care physician (PCP) must be chosen to coordinate all care; mental health services not provided by a PCP require a PCP referral under these Plans.
- Out of state employees, whose permanent residence is outside of Connecticut, may select from the two Out of Area Plans.

Non-emergency admissions to a Hospital, Skilled Nursing Facility or Specialty Hospital require Prior Authorization, including those with a behavioral health diagnosis (e.g., Residential Treatment Center or Substance Abuse Treatment Facility). See page 47 of the SPD for a comprehensive list of services requiring Prior Authorization. The Anthem plans also require prior authorization after the 20th outpatient mental health and substance use disorder visit.

The Plan also provides coverage to its members for Employee Assistance Programs with multiple vendor arrangements, prescription drugs (through CVS Caremark), and dental benefits.

In 2011, as a result of a collective bargaining agreement, the State implemented the Health Enhancement Program (HEP), a value based insurance design (VBID) program. State employees, certain retirees, and their dependents that enroll in the HEP program are required to obtain age and gender specific preventive services. Enrollees who are identified with one of five medical conditions (diabetes types I and II, asthma and Chronic Obstructive Pulmonary Disease (COPD), coronary artery disease, hypertension, and hyperlipidemia) must also adhere to certain condition-specific education requirements. The enhanced

benefit design reduces copays for certain services to remove barriers to care for these services. The State has contracted with CMSI to provide compliance monitoring and chronic condition counseling services in connection with HEP. CMSI has contracted with Conifer Health Solutions to provide data warehousing services.

Active employees contribute to their health coverage via bi-weekly payroll deductions based on the medical plan chosen and their participation (or not) in the HEP program.

Should a firm be selected to perform carve-out Behavioral Health services it will be required to provide monthly claims information to the State's data aggregator, Conifer Health Solutions, to help identify the prevalent health risks within the participant population, predict the financial impact of those risks, and possibly target them for additional intervention through utilization review, case management, wellness and/or disease management services.

The Plan currently maintains non-grandfathered status under the provisions of the Affordable Care Act. It is also compliant with the Mental Health Parity and Addiction Equity Act.

Exhibit A is the Plan's current Summary Plan Document for all benefit coverages. Additional information about the Plan can be found at its website, <http://www.osc.ct.gov/benefits/medical.htm>.¹

B. OBJECTIVE

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY to identify sources that could provide a carve-out Behavioral Health program on an Administrative Services Only (ASO) basis. The information provided in the RFI is subject to change and is not binding on OSC. OSC has not made a commitment to procure any of the items discussed, and release of this RFI should not be construed as such a commitment or as authorization to incur cost for which reimbursement would be required or sought. All submissions become OSC property and will not be returned.

The Plan is inviting you to respond to this RFI to provide a carve-out Behavioral Health program on an Administrative Services Only (ASO) basis. The desired ASO services include the following:

- BH network (acute hospitals, residential treatment facilities, intensive outpatient services, and all BH professional services), including a demonstrated capacity to treat all levels of care for substance use disorders within all segments of the population (adult, adolescent, male, female, and certain categories of law enforcement and first responders).

¹ The SPD prevails in any instance of a discrepancy with other plan description materials.

- BH claims administration and appeals
- BH utilization management with prior-authorization (all inpatient and extended outpatient days beyond 20 visits for members enrolled in the Anthem plans) and case management

For information and planning purposes OSC is seeking information from vendors capable of working with the State on the implementation and maintenance of a program to promote cost-effective, quality management of behavioral health services for State employees, retirees, and their eligible dependents. **The services contemplate duplication of the current plan designs, claims payment and utilization/care management services for both the in- and out-of-network BH benefits, coordination of prior authorization of inpatient stays and extended outpatient visits (beyond 20) related to behavioral health, coordination with POE-G Plan enrollees' PCP's for referrals for BH services, provision and receipt of claims information with the medical plans for appropriate administration of integrated plan design features such as deductibles and out-of-pocket maximums, and furnishing claims information to the State's data aggregator.**

C. REVIEW CRITERIA

The OSC has retained Segal Consulting to assist in the review of the responses for completeness and responsiveness to the RFI and to review such responses with the Plan. Each response shall be reviewed in accordance with the State's criteria and other relevant factors. Responders are requested to respond only to specific questions asked.

The OSC may request interviews to assist in the review of responses received.

Review of the responses will also include the following criteria:

1. The value of the BH services offered, taking into consideration how closely the BH services conform to requested plan designs, as well as additional services offered.
2. Availability of a network of BH providers deemed sufficient to serve the needs of all plan participants, with consideration being given to current patient/provider relationships and the varied behavioral health needs of a governmental workforce (e.g., first responders, law enforcement, administrators, teachers, and other collectively bargained employees). The capacity to provide all levels of care for the treatment of substance use disorders to all segments of the population (adult/adolescent, male/female, and those who require protection/anonymity as first responders and law enforcement personnel).

3. Experience of the firm in general including the firm's references or other public sector plan sponsors.
4. Qualifications of the firm, financial, and otherwise, regarding these services and products and adequacy of recommended staffing.

SECTION II INSTRUCTIONS

Below are the general requirements for submitting responses. These general requirements may be modified or waived at the Plan's discretion.

1. **Intent to Respond:** Any entity that intends to respond to this RFI is requested to *complete and return the Intent to Respond form no later than November 14, 2016*. Upon receipt of the completed Intent to Respond, OSC will provide instructions for accessing a Secure File Transfer portal to obtain copies of the following Exhibits to be used in responding to the RFI:

Exhibit A Summary Plan Document (SPD)

Exhibit B Summary of Participants by Zip Code

Exhibit C Questionnaire Excel Spreadsheet

2. **Costs for Response Preparation:** Any costs incurred in preparing or submitting responses are the responders' sole responsibility. Responses will not be returned.
3. **Time for Acceptance:** The vendor agrees that fees in its response will be valid for a period of at least 180 days. Late responses may not be considered.
4. **Commissions.** All fee information must exclude commissions.
5. **Plan Administration:** The responder agrees to that its response is based on the plan designs described in this RFI.
6. **Exceptions:** Any exceptions to terms, conditions or other requirements in any part of these specifications must be clearly pointed out in the appropriate section of the response.
7. **Responder's Representative:** The response must be signed by a legal representative of the responding organization.
8. **General Compliance:** All responses should encompass administration of BH services in a manner that is consistent with applicable federal and state laws and regulations, including the Mental Health Parity and Addiction Equity Act (MHPAEA) and its regulations.

9. **Claims Data.** Under the arrangement contemplated all claims data received by the responder would be the property of the State and available upon request at no charge. In addition, the responder would be expected to provide claims information on a timely basis (to be mutually agreed upon) to the medical plans for appropriate administration of integrated plan design features such as deductibles and out-of-pocket maximums, and provide claims information to the State's data aggregator.
10. **Right to Audit.** All responders agree to extend to the State the right to an independent audit by a firm or organization retained by the OSC.
11. **Confidentiality:** Any information released pertaining to this RFI is be kept in strictest confidence, and it is only under adherence to this request that we are delivering this RFI/information to prospective responders. This RFI/information may be shared only within your organization for purposes of preparing your response. As such, this RFI /information may not be copied or reproduced without prior written consent for other purposes and will not be disclosed to third parties.

It is assumed that all responses submitted adhere to the preceding conditions, unless otherwise noted in the response. Failure to meet any of these conditions may result in the disqualification of your response.

TIME TABLE

In order to promote timely completion of this project we have established the schedule below. Vendors submitting affirmative responses on the Intent to Respond must agree to adhere to this timetable.

Action	Due Date
RFI Released	November 7, 2016
Intent to Respond Reply Due	November 14, 2016
Vendor Questions Due	November 23, 2016
Respond to Vendor Questions	November 30, 2016
Responses Due	December 14, 2016
Analysis of Responses	January 2017

QUESTIONS

Questions regarding this RFI should be submitted by email to the following address: osc.rfp@ct.gov no later than 2:00 p.m. on Wednesday, November 23, 2016. Answers to questions will be transmitted by Wednesday, November 30, 2016. No phone calls will be accepted.

SUBMISSION OF RESPONSES

To be considered, RFI responses (an original plus ten copies) must be received no later than 2:00 p.m. on at the below address. Hard copies must also be accompanied by two (2) electronic copies on CD/DVD format.

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
Attention: Sarah Ormerod
Administrative Services Division
55 Elm Street, Third Floor
Hartford, CT 06106

SECTION III

QUESTIONNAIRE

You are requested to respond to all of the following questions in detail. Reference should not be made to a prior response nor should an overall response be used to answer more than one question. Each question has been written to address a specific area of concern and not general concepts of mental health programs and their operation. A full answer to each question is required even when such answers may appear repetitious.

OWNERSHIP

1. In what city and state and under what formal name is your organization incorporated?
2. Is your organization publicly or privately owned?
3. Please identify all owners with 10% or more interest in your organization. If any of the listed owners are entities other than a natural person, please list all owners of 10% or more of that entity as well.

ORGANIZATION

1. Provide the names and positions of officers and board members and whether they represent any hospital, physician, medical association, or other interest.
2. Provide the address and telephone number of the principal service office and the addresses of other locations that would provide services to the Plan and describe what those services are.
3. Indicate the geographic limits of your service capabilities for BH services.
4. How long has your firm been providing BH services?
5. List any behavioral health specific accreditations your organization currently holds.
6. Please complete the following:

	5 Years Prior	1 Year Prior	Current
Number of Clients			
Number of Lives			

7. Has your company, within the last five years, gone through any reorganizations, name changes, or ownership changes resulting from sales, mergers or other circumstances? If so, elaborate.
8. Do you anticipate any major changes to your organization or structure in the next 12-24 months, such as mergers or acquisitions? If so, elaborate.
9. Provide, as references, the names, addresses, and telephone numbers of three accounts (preferably public sector groups) that use your BH services.

Name	Address	Telephone Number

10. Have any contracts been terminated by an enrolled group within the last three years? If yes, indicate which groups and their reasons for termination. Provide the names and telephone numbers of representatives of three terminated groups, if any.

Name	Address	Telephone Number

11. Indicate **any** service included in your response offering for which your firm subcontracts.
12. Is any portion of your organization's revenue derived from providers of service? If so, please explain.
13. How does your firm distinguish itself in the behavioral health industry, and how would you utilize those distinguishing advantages in serving the Plan's diverse national population?

LEGAL

1. Indicate whether your organization has non-profit or for-profit status.
2. Indicate whether your organization is a defendant in any type of litigation. Please provide information regarding any type of lawsuit in which your organization is involved.

3. Describe your organization's liability insurance (nature of coverage, carrier, individual maximum, and aggregate maximum).
4. Describe the type of contractual relationship that you would propose between your organization and the Plan.
5. Provide a sample contract for review.
6. Would you agree to a contract provision that provides the State or its designee with the right to audit the performance of your organization and the services provided? Please indicate what services, records, and access will be made available to the State at no additional charge for the purposes of such an audit, and the frequency and notice provisions that your organization would desire in connection with such an audit provision.
7. Do you have a contractual relationship with third-party administrators/organizations in which you pay service fees or other fees for which the Plan would be directly or indirectly charged? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship.
8. Does your organization help resolve disputes between purchasers and providers regarding charges and the delivery of services?

HIPAA PRIVACY/SECURITY AND HITECH

1. Please confirm that the services proposed include your status as a Business Associate as defined in HIPAA and the HITECH Act.
2. Describe in general your understanding of your legal responsibilities as a HIPAA Business Associate with respect to compliance with the HIPAA privacy and security and HITECH breach rules.
3. Have you undertaken a HIPAA security risk assessment? If no, explain why not. If yes, provide the name of the firm that conducted the assessment, the time period during which the assessment was conducted, an overview of the most significant findings, and any actions you have taken since the assessment was completed to enhance your security policies, procedures and protocols.
4. Do you have written HIPAA privacy, HITECH breach, and HIPAA security policies and procedures, and is a copy available to the State on request?

5. Please name your HIPAA Privacy and Security Official(s). If you do not have them, explain why not.
6. How often do you train employees on HIPAA privacy and security and on your HIPAA policies and procedures, and how is that training conducted?
7. Have you had a breach of unsecured PHI in the last three (3) years? If yes, describe the incident, explain how you investigated the incident and mitigated its effects, and indicate whether you reported the breach to the HIPAA covered entity, to affected individuals, and/or to the Department of Health and Human Services.
8. Describe the security protocols that you follow when transmitting electronic protected health information.
9. Do you utilize electronic medical records (EMRs), mobile applications, or other health IT technology as part of the proposed services? If so, please explain.
10. Do you maintain “psychotherapy notes” as defined in the HIPAA privacy rule? If so, for what purposes do you use and/or disclose these notes (with or without a HIPAA authorization)?
11. Do you intend to use any type of subcontractor to perform the services? As to each entity that might have access to the State’s protected health information under that arrangement indicate the identity of each entity, the services it would perform, and whether you have a signed HIPAA Subcontractor/Business Associate Agreement in place with that subcontractor.
12. Do the federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records (42 C.F.R. Part 2) affect whether and how you would release patient information to the State? If yes, describe how these regulations would affect the release of such information.

ACCOUNT CASE SERVICES

1. Confirm your organization is submitting a response based on OSC’s current plan designs’ behavioral health benefits as outlined in Section I and Exhibit A. If not, please explain. Please note any deviation(s) from the current plan designs.
2. Confirm that your response includes providing the Plan’s Mental Health and Substance Use Disorder Services as described on pages 59 through 61 of the SPD, and the Plan’s behavioral health Therapy Services (e.g., Autism, Early Intervention, and Electroshock) as described on

pages 68 through 71 of the SPD, including coordination of periodic treatment reviews with the patient's other medical and prescription drug providers as medically necessary/appropriate.

3. What programs would be available to the Plan under your response Complete the following table (complete the table on the "Account Case Services" tab in Exhibit C):

Services Offered	Yes or No	Comments
24-hour 1-800 telephone access. Please indicate if offering a dedicated line, answered line, and/or automated voice response		
Telephone crisis intervention		
On-site crisis intervention		
Management/supervisor training		
Print/provide educational material for members (i.e., enrollment, program offerings, information related to conditions, etc.). Provide samples.		
Print/provide information on how to use the offered programs. Provide samples.		
Print/provide wellness/behavioral health information/seminars as requested by the Plan (provide samples)		
Attend meetings/health fairs as requested by the Plan		
Member and Plan on-line access (e.g., provider directory, claims and eligibility information, educational material, etc.)		
Inpatient and outpatient network of BH providers		

4. Which of the following information or services would be made available via a web site or mobile application, (e.g., smartphone or iPad)? Check all that apply.

- ☐ Providers can verify eligibility online
- ☐ Providers can submit claims online
- ☐ Providers can check claims status online
- ☐ Members can check benefits online
- ☐ Members can search for a network provider online
- ☐ Members can access educational information
(Provide what types of information are available)
- ☐ Plan can access account management reports online

5. If members can search for a network provider online, what information is provided in online network directories? Check all that apply.

- ☐ Provider name
- ☐ Office hours
- ☐ Office locations
- ☐ Degree/discipline (i.e., MD, psychologist)
- ☐ License or board certification
- ☐ Clinical specialty (i.e., depression, eating disorders, disorders of childhood, adolescent treatment, substance use – alcohol and opioid use)
- ☐ Quality information
- ☐ Cost information

- ☐ Languages spoken
- ☐ Providers' photo

6. Describe your online resources for members that would be included in your standard fees. Describe your mobile application resources for members that are included in your standard fees. Describe services available for additional fees and provide the fees for each. Can the website be Plan-specific customized? If so, is there an additional fee to do so?
7. Please list standard communications materials available to the Plan and its participants with regard to participant enrollment, program utilization, ID cards, program description, etc. Please indicate whether your organization would be willing to customize its standard materials for the Plan, and, if so, indicate any additional fees for customization.
8. Please list all forms that would be used in the administration of this plan (e.g., claim form, EOB) that are included in your standard fees.
9. Please confirm your ability to accept monthly electronic submissions of eligible participants as submitted by the Plan. Indicate any requirements in order for you to capture and maintain this information.
10. Please confirm your ability to provide claims information to the medical carriers for appropriate administration of integrated plan design features such as deductibles and out-of-pocket maximums, and provide claims information to the State's data aggregator.
11. Please confirm your ability to coordinate PCP referrals for enrollees in the POE-G Plans.
12. Please confirm your ability to provide and coordinate inpatient prior authorizations for inpatient stays and for extended outpatient visits (beyond 20).
13. Are you able to provide TeleHealth services? Please explain. Do your BH services include telephonic therapy visits? Do you utilize case conferences, and if so what is that process? Indicate what TeleHealth services are included in your standard fees versus what is not.
14. Describe your experience with, your network, your programs, and the services and support that you can provide for the treatment of children diagnosed with Autism Spectrum Disorders.
15. Describe your experience with, counseling available for, and programs, services, communication material, support, etc. that you can provide regarding:

- a. Opioid addiction/treatment
 - b. Alcohol use disorder treatment
 - c. Tobacco addiction
 - d. Weight loss management
16. Given the chronic nature of eating disorders and the levels of care that can be involved, describe the counseling resources and facilities that are specialized in this area and available within your network. Please provide information about best practices and research conducted by your organization in this area of treatment.
17. Do you offer ongoing wellness coaching to patients? Would you be willing to refer to another vendor for such services?
18. Answer the following questions regarding any behavioral health – medical – prescription drug integration protocols your organization offers/typically provides to identify and engage individuals in “at risk” medical populations (e.g., diabetes, heart disease) that would benefit from but are not accessing BH benefits and services. Include the following:
- a. Whether the program is included in your core product or whether it is a “buy-up” product
 - b. Target population(s)
 - c. Protocols for identification of the “at risk” members in the target populations
 - d. Protocols for cross referral and engagement
 - e. Nature and frequency of member interventions (i.e., education, coaching)

CRISIS INTERVENTION

1. In an emergency or crisis situation, what action is taken to assist the troubled member? How quickly do appropriate providers return emergency phone calls?
2. Are emergency calls always handled live by a counselor and what are the credentials of the staff members answering these calls? If not, during what hours of the day would members reach an answering service or system? Does your answering service or system provide the necessary

phone numbers and information to enable callers to reach professional counselors and professional providers?

3. Do phone counselors ever remain with a patient for further, long-term, even in-person treatment or as case workers?
4. What are the credentialing distinctions for phone counselors and other counselors or case workers?
5. If a patient is comfortable with a particular counselor can you ensure a continuum of care with that individual? Please describe this process.
6. What special training do intake staff and counselors receive with regard to crisis intervention and emergency assistance?
7. What procedures do you have in place for monitoring a patient's status following the crisis? Is there a formal process in place?
8. Do you provide access to peer counseling through community resources? Do you track engagement with peer counselors following a crisis?
9. Are you able to handle onsite critical incident stress management needs? If so, please describe your policy and experience in this matter.
10. How quickly can you provide on-site response to a critical incident?
11. Describe the manager/supervisor support you provide in response to a critical incident.
12. Can you and your network of BH providers provide tailored programs for first responders and court officials who require anonymity? Please describe.

CLAIMS PROCESSING AND CUSTOMER SERVICE

1. Please indicate in your response the identity and location of the claim office(s) that you would assign to the State?
2. What is the average number of years of experience of your claim adjusters in that office?

3. Please indicate whether you would need to hire additional claim adjusters to administer the services identified in this RFI and if so indicate the number of new staff that would be required.
4. Describe the claims payment process from date of receipt to full adjudication of checks to providers or patients. Does your system verify the appropriateness of the billed charges? Please describe your process in detail. If the process is different for network and non-network claims, please discuss separately.
5. What was the percentage of all claims that were submitted electronically by network providers in 2015?
6. Confirm claims and other standard transactions are handled in a way that complies with the HIPAA Electronic Data Interchange (EDI) standards and operating rules.
7. Do claims adjusters and customer service personnel have online access to plan designs, your payment policies, eligibility, and payment histories at their primary workstations?
8. For the claim office(s) you would propose for these services, what is the average turnaround time for clean and complex claims in-network? For out-of-network claims?
9. For the claim office(s) you would propose, please provide the following for the last two calendar years:
 - Financial accuracy as a percent of total claims dollars paid (include over and underpayments)
 - Coding accuracy as a percent of total claims submitted
10. How do you avoid duplicate payments of the same claim? If duplicate payments or overpayments are made, what are your procedures for recovery of the overpayments or duplicate payments?
11. Describe how eligibility is verified. Provide a copy of your required eligibility file layout.
12. Under the proposed services requested by the State, would its participants have access to a toll-free number for customer service and claims inquiries? Could the number be dedicated to the State's Plan? Would members be able to access a customer service representative? Please specify what hours (include time zone) are available for members to speak with a customer service representative, and indicate where customer service representatives are located.

13. Are members able to view the status of claims online?
14. Do you use a language service? If so, how often has your staff used this service in the past twelve months?
15. What languages are available directly through your own customer service staff?
16. Do you have an automated voice response system (AVR) for customer service? Please specify what hours (include time zone) the system is accessible, what information and/or transactions the members would be able to utilize with this system, and what information the member must provide to access the system.
17. Describe your appeals process for denied or rejected claims. Do you have a formal written appeal/grievance/reconsideration process?
18. What percentage of claims are denied and for what reasons?
19. Is information regarding the option for an appeal, the timeframe, and the mailing address and all other information required for processing non-ERISA appeals in the body of or attached to all claims and appeal notification letters?

DATA REPORTING & MISCELLANEOUS CAPABILITIES

1. Describe the data elements maintained in your system. Specifically:
 - a. Is your system able to capture primary and secondary diagnoses? What coding system is used?
 - b. What history is captured? By whom and how accessible is it? Is it available electronically? For how long is it accessible?
 - c. Is data maintained (and available in reports) both in the aggregate and by provider?
2. Do you track and report key measures related to outcomes and performance, including the following:
 - a. Follow-up care for children prescribed ADHD medication (claims based measure)?
 - b. Metabolic monitoring for children and adolescents on antipsychotics (claims based measure)?
 - c. Depression remission at twelve months (potentially an EHR measure)?
 - d. Depression remission at twelve months - progress towards remission (potentially an EHR measure)?
 - e. Child & adolescent major depressive disorder and suicide risk assessment (potentially an EHR measure)?
3. Can you track and report key demographic information, such as by age, sex, race and ethnicity?
4. Please describe the reports available for your BH services. Please list the reports you provide on a regular basis and state the frequency with which they are available. Are reports available online and would they be available to both the OSC and its consultants? Do you have system capabilities to provide high cost case reports? Assessment reports and/or high utilization reports to identify patients for potential fraud and/or abuse?
5. Can you provide custom reports or accommodation of unique data file requests at no additional charge? If not, please explain.
6. What is the average turnaround time for custom reports and data requests?

IMPLEMENTATION

1. How much advance notice would be required to alert, educate, and familiarize participants about the specifics of your programs?
2. Provide an outline for your implementation process, outlining tasks, timelines, and parties responsible.
3. Describe what would be the State's role in any implementation process?
4. What is your recommended process for handling transitions where a person is in treatment with a provider not in your network on the date of implementation? Do you permit a grace period? If yes, for how long?

BEHAVIORAL HEALTH NETWORK

General

1. How many network inpatient facilities have JCAHO accreditation in Connecticut?
2. How many network rehabilitation facilities have CARF accreditation in Connecticut?
3. What is your approach for providing a seamless network/transition to participants from EAP to BH services?
4. What is your approach for providing a seamless network/transition to participants from inpatient to outpatient services?
5. How are inpatient and outpatient facilities and practitioners linked with regard to eligibility data, treatment protocols, etc.?
6. How do you coordinate treatment with primary care physicians? Please describe the protocol that a behavioral health provider uses to reach out to medical providers who are also treating the patient.
7. How do you coordinate services, care, and data with the patient's medical plan provider? The State's prescription drug administrator (currently CVS Caremark)? Include in your answer how

you would ensure that out-of-pocket costs accumulate to deductibles and maximums that may apply.

8. Do you have a mechanism in place to assist prescribing doctors in your network in the use of the State's prescription drug formulary with its PBM?
9. How would you coordinate prior authorization of inpatient stays and extended outpatient visits (beyond 20)?
10. Are there any specific administrative procedures or information you envision that your organization might need from the State?

Staffing and Provider Credentials

1. Please detail the composition of your professional provider network by providing the number of providers in each of the disciplines listed below specific to the indicated locations. Note that providers may be counted more than once if they practice in more than one location. (Complete the table on the "BH Professional Providers" tab in Exhibit C.)

Location	Psychiatrists, Board Certified/Eligible	Doctoral-Level Psychologists	Licensed Clinical Social Workers	Other Masters Prepared Clinicians
All States				
Connecticut				

2. Define the credentials ordinarily held by each of the different types of professionals shown in the table above.
3. Do you have psychiatrists who specialize in treating children and adolescents in your network? If so, how many and in what states do they practice? How many in Connecticut?
4. Provide the number and percent of participating professionals that were terminated from your network in the past 24 months:

	# of Professionals	% of Professionals	Reasons for Termination
By Your Organization			
By Professional			

5. Please detail the composition of your facility network by providing the number of facilities providing each of the types of care listed below specific to the indicated locations. (Complete the table on the “BH Facilities” tab in Exhibit C.)

Location	Total Facilities	Acute Care	Partial Day Care	Residential Treatment	Intensive Outpatient (IOP)	Other
All States						
Connecticut						

6. Please describe other step-down levels of care that are provided by facilities in your network, and how many total facilities provide each in the service area as described.
7. Provide the number and percent of participating facilities that were terminated from your network in the past 24 months:

	# of Facilities	% of Facilities	Reasons for Termination
By Your Organization			
By Facilities			

8. Provide information regarding your network coverage for key clinical specialties, cultural diversity needs, and language needs.
9. What credentialing process and criteria are used to select facilities and treatment programs? Professional providers? If the criteria are different for each type of provider, please specify.
10. For your network of professional providers, complete the following table. (Complete the table on the “BH Staffing Credentials” tab in Exhibit C.) Check off those elements that are included in the selection process and provide the percentage of network physicians that satisfy the following selection criteria elements.

Criteria	Standard Selection Criteria (check if yes)	Percentage of Providers that Satisfy Criteria	Comments
Require Unrestricted State Licensure at the Individual Practitioner Level			
Require Advanced Degree (List Degrees Required)			
Review Malpractice Coverage and History			
Require full disclosure of current litigation & other disciplinary activity			
Require Signed Application/Agreement			
Require Current DEA Registration			
Review adherence to state and			

Criteria	Standard Selection Criteria (check if yes)	Percentage of Providers that Satisfy Criteria	Comments
community practice standards			
On-site review of office location and appearance			
Review hours of operation and capacity			
Consider Hospital Admitting Privileges			
Require Board Certification			
Review Practice Patterns & Utilization Results			
NCQA Accreditation			

11. Do any employees in contact with patients not hold a degree related to behavioral health? Please explain in which situations/level of care this would be the case.
12. Include the minimum required malpractice coverage per individual practitioner, per occurrence. If the process differs by type of provider, please indicate and describe separately. Please also provide the minimum required malpractice coverage per facility per occurrence.
13. Describe the re-credentialing process; include timing and percentage of facilities and professionals that are re-credentialed each year. Provide the number of years that a provider contract is in effect.
14. How do you monitor the quality of care and cost efficiency of the providers in your network?
15. Under what circumstances would a facility and/or professional provider be removed from your network, and how are patients and the health plan providers who may handle referrals notified?
16. Based on 2015 book-of-business, complete the following table (on the “SUD Facilities” tab in Exhibit C) for network of facilities used to treat substance use disorders in the state of Connecticut:

	Acute Inpatient	Intensive Outpatient	Partial Hospitalization	Aftercare/Transitional Living w. Clinical Oversight
Number of Facilities				
Average Waiting Time for Admission				
Average Length of Stay				

17. Describe any centers of excellence in your network for the treatment of substance use disorder. This may include specialization in the treatment for adolescents, women, law enforcement, etc.

Quality Assurance / Audits

1. What process do you use to track patient satisfaction with your provider network?
2. Do you currently perform membership satisfaction surveys? If so, summarize the latest results of the survey for your Book of Business, and for public sector groups, if available.
3. Summarize the quality improvement programs your organization has in place to ensure that proper treatments are being provided. Describe the most important actions your firm has taken in the past year, based on these studies, to improve performance.
4. How do you monitor and ensure that individuals are:
 - a. Adequately screened/assessed without delays or unreasonable wait times?
 - b. Properly triaged?
 - c. Appropriately counseled?
5. How would you assure the following:
 - a. Initial provider visit is scheduled in a timely manner, to the satisfaction of the patient?
 - b. Return phone call to the patient, from your staff, is considered timely by the patient?
 - c. Professional communication by your staff?
 - d. Accommodation of counselor visits to the working schedule of the patient?
 - e. Satisfaction by the patient, in the number of visits received and quality of service provided?
6. Do you profile providers to track outcomes? What data do you maintain on providers' patterns and how does that data impact your referrals to those providers?
7. Describe the procedures in place to audit the quality of care being rendered by BH providers.
8. Please provide the following information regarding provider audits.

	On-Site	Total
Percent of providers audited annually:	%	%
Is the right to audit included in your standard provider contracts?	Yes or No	

9. Do you monitor individual professional provider treatment patterns? If so, what action is taken with providers who have illustrated improper patterns?
10. Describe quality assurance measures that address the treatment of substance use disorders, such as: adequate response to crisis, adequate access to specialty facilities/providers that specialize in detox/intensive outpatient, and even adolescent care.
11. Describe the member grievance protocols in place.

Network Access

1. Using the census data found in Exhibit B, please complete the “Network Access” tab in Exhibit C by preparing a network match analysis. Separately indicate what percentage of Plan members **(excluding dependents)** have access to at least one BH acute care hospital/facility within 15 miles, one BH residential treatment facility within 15 miles and two BH professional providers within eight miles. Please show separate results for BH acute care hospital/facilities, BH residential treatment facilities and BH professional providers for (1) all members and (2) for Connecticut members. **Only include providers accepting new patients in measuring access:**

State/Criteria	Number of Members Meeting Access Standard (excluding dependents)	Percentage of Members Meeting Access Standard (excluding dependents)	Number of Providers Accepting New Patients
All Plan members (excluding dependents)			
- Members within 15 miles to 1 BH acute care hospital/facility			
- Members within 15 miles to 1 BH residential treatment facility			
- Members within 8 miles to 2 BH professional providers			
Connecticut members (excluding dependents)			
- Members within 15 miles to 1 BH acute care hospital/facility			
- Members within 15 miles to 1 BH hospital/facility			
- Members within 8 miles to 2 BH professional providers			

2. In Exhibit C, the “Inpatient” tabs contain listings of the BH Inpatient hospital/facilities used by the Plan’s participants based on a June 1, 2015 through May 31, 2016 date of service. Indicate in the spreadsheet with a “Yes/No” the hospitals that participate in your network.
3. In Exhibit C, the “Outpatient” tabs contain listings of the BH Outpatient hospital/facilities used by the Plan’s participants based on a June 1, 2015 through May 31, 2016 date of service. Indicate in the spreadsheet with a “Yes/No” the hospitals that participate in your network.
4. In Exhibit C, the “Professional” tabs contain listings of the BH professional providers used by the Plan’s participants based on a June 1, 2015 through May 31, 2016 date of service. Indicate in the spreadsheet with a “Yes/No” the providers that participate in your network.
5. Do you currently have an adequate number of staff and network providers to provide BH services for the Plan? Provide your criteria for determining coverage adequacy. If not, do you propose expanding your staff or network so that all regions are covered adequately?
6. Could you provide the behavioral health program using the existing Anthem and UHC networks? Explain how this would work, and any advantages/disadvantages.
7. Would you be willing to recruit Anthem or UHC providers, particularly for current patient/provider relationships, who are not currently in your network?
8. What procedure must be followed if a participant or the Plan requests a provider(s) be included in your network?
9. Can providers limit the number of patients/cases they accept? If so, how is/are the limit(s) determined?
10. What percentage of BH professional providers in your network are at full capacity and are not accepting new patients?
11. What steps would your firm take to increase appropriate utilization of in-network versus out-of-network BH providers?
12. What are your firm’s standards for timely access to providers for:
 - a. Routine care

- b. Urgent care
 - c. Emergency Care.
13. How would the Plan be notified of hospital and or health care facility additions and terminations during the plan year? How are participants notified of hospital and or health care facility additions and terminations during the plan year?
 14. How would the Plan be notified of physician/practitioner additions and terminations during the plan year? How are participants notified of provider additions and terminations during the plan year?
 15. What happens to current patients of terminating provider?

Network Provider Reimbursement

1. Please indicate the forms of reimbursement that you negotiate with network providers. (Complete the tables on the “Network Provider Reimb” tab in Exhibit C.) If more than one type of arrangement is negotiated for a specific provider type, please indicate the percentage of hospital/facilities and professional providers with which you have each arrangement.

Hospital/Facility Type	Discounted Fee for Service	Per Diem	Per Case	More Than One Type of Arrangement
Acute Care				
Partial Day Care				
Residential Treatment				
Intensive Outpatient (IOP)				
Other Facilities				

Professional Type	Discounted Fee for Service	Capitation	Salaried	More Than One Type of Arrangement
Counselors				
Psychiatrists				
Psychologists				
Other Professionals				

2. If capitated arrangements are negotiated, please describe what services are capitated and how capitations are derived. Are supplemental capitations available?
3. With regard to facility reimbursement, what is the average percentage savings from billed charges that you expect to achieve?

4. With regard to professional providers, what is the average discount from charges that you estimate your current contracts can produce?
5. Please indicate your average negotiated discounts for your network hospitals/facilities. These discount percentages shall be based on actual achieved discounts and shall not be based on projected or expected discounts:

Inpatient	Partial Day Care	Residential Treatment	Outpatient

6. Please indicate your average negotiated discount for your network professional providers. These discount percentages shall be based on actual achieved discounts and shall not be based on projected or expected discounts:

Psychiatrists, Board Certified/Eligible	Doctoral-Level Psychologists	Licensed Clinical Social Workers	Other Masters Prepared Clinicians	Licensed or Certified MAP Counselors

7. Please indicate in Exhibit C on the “Inpatient”, the “Outpatient” and “Professional” tabs your average discounts for each provider. Indicate “N/A” if the provider is not in your network.
8. How often are network reimbursement rates, fees, and capitations updated?
9. Please describe your behavioral health specific experience with alternate payment arrangements (e.g., case rates, bundled payments, shared savings, partial capitation, performance-based incentives).
10. How do you identify providers potentially engaged in abusive or excessive billing practices? What corrective measures do you take with such providers? Under what circumstances are such providers terminated?
11. Please state any relationship your organization has with any inpatient or outpatient mental health facility (contractual or otherwise, financial or otherwise) that is not common to all facilities in your network.
12. Does your firm promote in-state / Connecticut facilities based on cost efficiencies and outcomes?

13. Based on the State's current benefits, describe how out-of-network providers would be reimbursed. How would you determine and define "maximum allowable" charges (e.g., own data, a percentile of Fair Health, relative value scale)?
 - a. For professional providers?
 - b. For hospitals/facilities (inpatient, residential, IOP, partial hospitalization, and outpatient)?

UTILIZATION/CARE MANAGEMENT

1. How would you work with clinicians to develop treatment plans at the onset of treatment and reassess, at various intervals, to determine transitions to different levels of care?
2. Explain the process required before a denial (of inpatient stay, continued outpatient visits, or other behavioral health services) is rendered. How is this coordinated with the patient's health plan provider?
3. How do you support and promote evidence-based treatment with your providers?
4. How would you assist (with the State's medical plan providers) to identify and provide outreach to individuals with behavioral health or substance use disorders? How would you assist individuals in accessing treatment?
5. Please confirm you would provide utilization/care management for both in-network and out-of-network BH hospital/facility and professional provider services.
6. Confirm you would provide concurrent review and periodic six-month treatment plan reviews for the treatment of Autism Spectrum Disorder, as described in the Summary Plan Description on pages 19 and 68, respectively?
7. Describe your broader view on best practices in behavioral health issues. Explain how you incorporate outcome data with other research to develop and shape treatment protocols on an ongoing basis?
8. Describe your utilization/care management procedures. Your answer should address:
 - a. Prior authorization
 - b. Concurrent and retroactive review of on-going treatment

- c. Large case management
- d. Discharge planning and aftercare
- e. Source of your review guidelines (e.g., in-house, American Society of Addiction Medicine (ASAM), Childhood and Adolescent Levels of Care Utilizations System (CALOCUS), the McKesson InterQual criteria, Hearst Health MCG Guidelines)
- f. Ability to provide utilization statistics and savings reports
- g. Appeals process
- h. Systems edits and on-line access to supporting information

For the components noted above, please provide:

- The credentials and qualifications of personnel performing the stated task
 - The timing requirements of each task
 - How standards were developed
 - How information is captured and results are monitored
9. In what situations would a provider/staff member provide onsite assistance to patients in the emergency department or other locations? Would this service be included in your basic fee? If not, please outline your fees.
 10. What is the process for assigning prior authorization, large case management cases and appeals to physicians for review? Would you coordinate these services with the medical plans?
 11. When is case management triggered for patients treated for substance use disorder? Eating disorder?
 12. What percent of cases typically require physician involvement?
 13. At what point is physician involvement initiated?
 14. In what form and how quickly is notification of admission/continued stay certification provided to the attending physician, hospital, patient, claim administrator, and plan sponsor?
 15. What specific criteria are used to identify cases for case management? When and how is case management initiated?

16. Describe in detail your method for calculating case management savings that result from your program.
17. Will you guarantee such savings estimates and to what extent?
18. How would you propose to measure savings?
19. Outline the steps you take upon identification of a dual diagnosis. Highlight how you assess primary versus secondary, whether they are to be treated simultaneously or separately, and how you coordinate the inputs of multiple caregivers, if called for.
20. What are your internal mechanisms for controlling outpatient costs? Are there incentives built-in to move patients from inpatient to outpatient?
21. Describe how you monitor utilization and readmission rates by facility, and reporting and targeting programs you provide to reduce any abuse at both network and non-network facilities.
22. Describe safeguards in place to prevent members from being steered by third parties to costly inpatient facilities, or facilities that are out of-network, or that may not provide quality care. What plan design recommendations do you have for the State? How do you manage patients that have already been steered to such facilities? How would you manage and minimize costs and exposure for both the State and the members?
23. What criteria are used to determine whether a patient should be treated for substance use disorder on an inpatient or an outpatient basis?
24. Do you ever recommend outpatient detoxification? Medication-assisted therapy? If so, under what circumstances do you do so and how are they monitored? Could you coordinate oversight of medication-assisted treatment with the State's PBM, CVS Caremark?
25. For cases involving detoxification and the treatment of addiction, do you request and review patient case history? Describe management extending beyond the determination of medical necessity, such as appropriateness of facility (logistically, based on patient profile, clinical oversight, etc.), frequency and cost of medical services, and discharge planning.
26. Provide a description of your service model when a member needs to go into an outpatient addiction recovery facility for **alcohol addiction**. Include in your response the type of facility

that would be recommended, length of treatment, treatment plan protocols, criteria for discharge, follow-up care, etc.

27. Provide a description of your service model when a member needs to go into an outpatient addiction recovery facility for **opioid addiction**. Include in your response the type of facility that would be recommended, length of treatment, treatment plan protocols, criteria for discharge, follow-up care, etc.
28. What is your experience with aftercare services involving other community resources, such as transitional sober living arrangements, peer support groups, etc.? Are you able to monitor the long-term engagement of a patient post-discharge in these programs? Are you able to track relapses and adjust treatment plans according to patient history?
29. How would your organization coordinate with the medical plans and the patient's medical providers regarding the care of a patient needing detoxification and treatment of addiction services, including follow-up care? The PBM?
30. How else would you involve the State and its service providers to collaboratively manage care? Please describe.
31. What experience does your organization have monitoring use of abuse-deterrent opioids versus non-abuse-deterrent opioids for treatment, and would you have any coverage recommendations (for behavioral health or prescription drug coverages) as a result of this experience?
32. Do you offer any utilization management programs regarding abusive drugs to ensure appropriate use and ensure appropriate quantities? Describe programs and services that you can provide regarding abusive drugs.
33. Describe how you manage drug testing / screening costs.
34. What savings (as a percent of total behavioral health claim costs) do you expect to achieve through reductions in inpatient utilization and outpatient provider services, fraud, review, and savings from adherence to cost-effective treatment protocols?
35. Does your utilization management program offer any other unique features/programs (e.g., management of stress, depression, eating and feeding disorders, schizophrenia, chronic disease, etc.)? Please describe.

36. With respect to all of your utilization management strategies that are non-quantitative treatment limits under MHPAEA (e.g., medical necessity determinations, determinations that proposed treatment is experimental or investigational, standards for provider admission to a network, provide reimbursement rates (in and out-of-network), restrictions based on facility type or geographic specialty, etc.), what documentation would you provide to the State that will enable the State to determine if the State applies these strategies comparably to medical and surgical treatment? Specifically, would you provide to the State as part of your response written documentation of the processes, strategies, evidentiary standards and other factors (including evidence) used by you to apply a non-quantitative treatment limit to BH benefits?
37. What assurances can you provide that by selecting you the State would remain in compliance with MHPAEA?
38. Will you provide your written criteria for medical necessity determinations, as well as other behavioral health protocols that you follow, upon request from the State, a member (or dependent), or a treating provider? Will you provide this documentation within 15 days of any such request?

SECTION IV
FEE INFORMATION

1. Please state fees in terms of a monthly self-insured rate per eligible subscriber for BH services for each of the next three calendar years (2017-2019). Please identify any start-up fee(s) separately and the reason the fee is required. If there are any limitations or exclusions not covered by your plan, or any underwriting requirements on which your fees are based, please note them as well. (Complete the table on the “Fee Information” tab in Exhibit C.)

	Monthly Rate per Eligible Subscriber (Employee/Retiree) ²		
	Year 1	Year 2	Year 3
BH Services			

2. Please list all services that would be covered in your BH services fee.
3. Please list all services that would not be covered in your fee for which the State might be charged separately. Provide descriptions and fees.
4. Are your fees based on an anticipated level of utilization by State members and their eligible dependents? If so, what level of utilization have you assumed? Would you adjust your fees retroactively for under or over-utilization?

² Subscriber is defined as excluding dependent counts. The Plan currently covers approximately 109,300 subscribers (55,000 active, 300 COBRA, 50,000 retirees and 4,000 Partnership subscribers).

SECTION V

PERFORMANCE GUARANTEE INFORMATION

The State would require specific performance guarantees to be set and measured annually. Indicate the percentage of administrative fees that you would propose to place at risk for each item listed in the table below.

Performance Guarantee Descriptions	Target	Measurement Definition	Measured BOB or Plan Specific?	% of Administrative Fees at Risk
<i>Clinical Customer Service</i>				
Average Speed of Answer	30 seconds average speed of answer	Calculated from the time a member selects an IVR choice to live answer by a live voice		%
Call Abandonment Rate	<4%	Percentage of calls that are placed in queue but are not answered because the caller hangs up prior to a live answer		%
<i>Quality</i>				
Complaints and Grievance Resolution	95% resolved within 20 calendar days	Metric time frame is in compliance with ERISA, URAC and industry standards		%
<i>Network Access: Provider Turnover, MHSA Provider Access and Appointment Availability</i>				
Provider Turnover	<5% Master Level Provider Turnover	Percentage of providers voluntarily leaving the Provider Network (Excluding those who retire)		%
	<5% Ph.D. Level Provider Turnover			%
	<5% MD Level Provider Turnover			%
MHSA Provider Access	Urban: 2 practitioners / 1 facility within 10 miles	Any market with 250 employees for practitioner standards and 500 employees for facility standards will be reviewed and reported annually		%
	Suburban: 2 practitioners / 1 facility within 15 miles			%
	Rural: 2 practitioners/1 facility within 30 miles			%
Provider Appointment Access	100% of Non-Life Threatening Emergent cases are offered access to care within 6 hours/ Life Threatening Emergent cases are offered care immediately (1 hour)	For urgent/emergent cases and routine access requests, appointment information is entered into designated system fields and is tracked quarterly and reported annually		%
	95% of Urgent cases are offered access to care within 48 hours			%
	100% of the time we will offer appointment assistance for an appointment available within 6 days, when requested by a member calling for Standard or Routine services			%

<i>Satisfaction</i>				
Member Satisfaction	90% overall satisfaction	Overall Satisfaction rated as “Satisfied” or better as reported on the Member Satisfaction Survey		%
<i>Claims</i>				
Turnaround time for processing of submitted claims within 14 business days	90%	Measured from the time of clean claims receipt to the time claim is processed for payment, denied, or pended for external information		%
Total Percent of Administrative Fees at Risk				%

1. Provide any additional performance standards and guarantees that you would be willing to include in a contract. List standards, measures, and range of penalties and incentives to which you are willing to agree to.

SECTION VI
CERTIFICATION FORM

As an officer of the following corporation: _____

I certify that all of the information included in this response for the State of Connecticut Office of the State Comptroller is true and accurate.

Signature: _____

Name: _____

Title: _____

Company: _____

Date: _____

8456564v3/13507.004

Return by fax (860-702-3662) or email: osc.rfp@ct.gov

INTENT TO RESPOND

Date:

Office of the State Comptroller
State of Connecticut Health Plan
Healthcare Policy & Benefit Services Division
55 Elm Street
Hartford, CT 06016
Attention: Ms. Sarah Ormerod

**Re: Office of the State Comptroller (OSC) State of Connecticut Health Plan
Request for Information for Behavioral Health Program**

Dear Ms. Ormerod:

This is to confirm that we have received the Request for Information for the referenced Program.
We wish to advise you that we

☐ will be submitting a response to your request;

☐ will not be submitting a response to your request.

We are not submitting a response because

Sincerely,

Name

Title

Company

(_____)_____
Telephone Number

E-mail Address