

State of Connecticut Medical RFP

In order to participate in this procurement follow the process below:

Go to <http://www.proposaltech.com/home/app.php/register>. Enter your email address into the field provided. No registration code is necessary. Click "Begin Registration." If you already have an account with Proposal Tech it will be listed on the registration page, if you do not, you will be asked to provide company information. Once your account has been confirmed, check the appropriate box for the RFP you're registering for and click the "Register" button. An invitation will be mailed to you within fifteen minutes. If you have any questions regarding the registration process, contact Proposal Tech Support at 877-211-8316 x84.

1 REQUEST FOR PROPOSAL INTRODUCTION

1.1 The Office of State Comptroller, State of Connecticut (the "State"), acting through the Health Care Cost Containment Committee ("HCCCC"), is soliciting proposals for vendors to administer its current self-insured medical benefits plans for active employees and non-Medicare eligible retirees, and their dependents. Due to collective bargaining contracts, the State must duplicate current plan designs and funding arrangements. In addition to providing benefits to State employees and retirees, the State also covers employees in the probate court system, General Assembly members, former legislators, and other groups, as authorized by statute.

The State also offers medical benefits through its current medical benefits vendor to local municipalities under the Connecticut Partnership Plan. It is the State's preference to work with an organization(s) that can administer both the State Plan and the Partnership Plan. Vendors must include quotes for the Partnership Plan in their proposal and can do so combined with their quotes for the State Plan or separately. The State reserves the right to elect to award benefits for the State Plan, the Partnership Plan, both plans or neither plan. Proposals submitted for only the State Plan or only the Partnership Plan will not be considered.

A complete listing of Partnership groups can be found here: <https://www.osc.ct.gov/ctpartner/members.html>

Currently, the State offers all plan designs through two carriers - Anthem BCBS and United HealthCare/Oxford. The plan design currently offered to Partnership groups is the State employee POS plan administered by United HealthCare/Oxford. Details of the operation for the Partnership Plan are attached as an appendix.

The current Medical Plan's contracts expire on June 30, 2020. The State of Connecticut is seeking a cost-effective solution that will match current benefit designs and provide high quality service to its covered employees, non-Medicare retirees, and their dependents through a network of providers. Proposals containing the lowest cost will not necessarily be awarded as the State recognizes that factors other than costs are important to the ultimate selection of the provider or providers of their benefit plan.

The State's medical benefits plans are defined through a collective bargaining agreement that remains in effect through June 2027. Therefore, it is imperative that entities responding to this RFP provide a proposal that duplicates the current benefit structure without modification. The State currently provides its employees access to a number of health benefits options, which are offered through two medical insurers, one PBM, and one dental insurer. Although there are currently two medical carriers, the structure of the benefits and plan designs are the same. The only substantive differences between the benefit options are the breadth of the networks and the pricing offered by each carrier.

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In 2011, in response to 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 are required to seek age-appropriate preventive services. Enrollees who are identified with one of five chronic 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. HEP reduces copays for certain services and prescriptions used to treat HEP related chronic conditions. Currently, there are 180,000+ participants in HEP under the State health plan; another 54,000+ members participate in HEP through the Partnership Plan.

Care Management Solutions, Inc. (“CMSI”), an affiliate of ConnectiCare, and a division of Wellspark has supported the HEP program since January 2013. CMSI uses a subcontractor, Conifer Value-Based Care, LLC, as a claims data aggregator, to identify at-risk individuals and to monitor member compliance with HEP preventive requirements. Conifer receives weekly claims feeds from the State’s PBM, dental and healthcare vendors to maintain HEP compliance data. Through an agreement with PatientPing, Inc., CMSI receives real-time notifications if a HEP member with a chronic condition is admitted to or discharged from a hospital or receives care at an emergency room.

Because enrollment in HEP is voluntary, the State requests that you provide proposals for both a HEP (Health Enhancement Program) option and non-HEP plan. See the benefit designs in the “Benefit Summaries” appendix for details of the HEP Benefit offerings.

The RFP requests proposals for medical benefits only. Benefits for Medicare eligible retirees are provided through a Medicare Advantage plan and are not part of this RFP. Pharmacy and dental benefits are also not part of this RFP.

The State requests that you provide rates and fees (if any) separately for each benefit described below. The State will consider combining all coverage with one vendor as well as working with a third party administrator using a leased or State specific network.

Entities responding to this RFP should also note that the State is requiring access to certain information and that detailed monthly claims data must be provided to the State’s data warehouse vendor, healthcare consultants and other partners as may be required for the administration of the plan. Submission of your proposal will acknowledge acceptance of these requirements. Claims must also be shared with the HEP administrator weekly and with Remedy Partners in real time. The financial requirements include initial and renewal pricing and projection controls.

Background

The State Comptroller is empowered by Connecticut General Statutes § 5-259 to arrange and procure a "group hospitalization and medical and surgical insurance plan" for employees and retirees of the State of Connecticut. In 2010, the State elected to provide these benefits on a self-insured basis. Public Act 10-174 affords the State the ability to offer the financial arrangement and services of these plans to local municipalities.

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The HCCCC was established through collective bargaining in 1985 and is composed of six labor representatives and six management representatives. It is responsible for implementing cost control measures, monitoring and improving plan quality, and implementing health promotion and wellness activities for state employees, retirees, and their eligible dependents.

The Health Enhancement Program (HEP) affects active employees, certain retirees, and their dependents. Upon initial medical benefit enrollment, employees decide if they will participate in HEP. Employees and eligible retirees are given the opportunity to opt out of the program or enroll in the program once per year during the annual Open Enrollment period. Participation requires that employees receive all age and gender appropriate wellness services during the year (e.g. physical exam, cholesterol screening, well-woman exam, and one dental cleaning) and diagnosis screenings (e.g. colorectal cancer screening, Pap smears, mammograms, vision exams). In addition, persons with any of five specified chronic conditions, namely Diabetes Type I & II, Heart Failure/Heart Disease (Coronary Artery Disease), Asthma and COPD (Chronic Obstructive Pulmonary Disease), Hyperlipidemia (High Cholesterol), Hypertension (High Blood Pressure), must comply with requirements appropriate to the proper care of the condition. The preventive visits are provided without charge to the employee and those with one or more of the specified conditions receive condition-related prescription drugs at reduced copays and will have copays waived for office visits related to those conditions. Employees who do not comply with HEP requirements or who choose not to participate in HEP face a \$350 annual deductible per-person (maximum of \$1,400 per family) for in-network care and pay \$100 more per month for medical and pharmacy coverage. Presently, over 95% of employees participate in HEP.

CT SmartShopper Rewards

In 2017, the State introduced the CT SmartShopper Rewards program, currently administered by MDx Medical, Inc. d/b/a Sapphire Digital (formerly "Vitals"). Effective July 1, 2020, the program will be administered by Health Advocate. This program provides cash incentives to State employees, certain retirees, and their dependents, who "shop" for certain health care services, such as ultrasounds, mammograms, MRIs and CT scans, knee, shoulder and hip surgery, and then obtain such services from high quality, lower-cost providers identified through the program. This program was implemented as a result of the latest Collective Bargaining Agreement (CBA).

Site of Service Program

In 2017, the State also introduced the "Site of Service" program for labs and diagnostic imaging services. State employees, certain retirees, and their dependents have 100 percent coverage (\$0 copay) for lab tests, X-rays and other high-cost imaging services, like MRIs and CT scans, when they select a preferred "Site of Service" (SOS) provider. Site of Service (SOS) providers are labs, radiology and imaging centers that have proven to deliver high-quality, low-cost services. If a provider is in network but is not designated as a Preferred provider, member cost share is 20%; members using out-of-network providers have a 40% member cost share. Breast ultrasounds and mammograms of all types are excluded from this program, and waivers are considered when proven to be medically necessary.

Centers of Excellence

In July 2020, the State will roll out a "Centers of Excellence" program (COE) to be administered nationally by Carrum Health and in-state by Remedy Partners. In addition, full concierge services to steer members to high quality, lower cost providers for certain medical procedures or screening and surgeries via COE will be provided by Health Advocate. This program applies to active and non-Medicare retiree members of the State's plan and participants in the State of Connecticut Partnership Plans.

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In partnership with Remedy Partners, the State has also entered into direct contracting negotiations with its hospital providers. The successful Vendor will be expected to support this effort and administer these negotiated payments on behalf of the State. Support shall include but not be limited to open and transparent access to existing carrier contracted rates and reimbursement methodologies, flexibility in administering alternative reimbursement fee schedules and structures as may be negotiated by the state plan, and data file sharing with related state employee health plan partners as described within this document.

Tiered PCP and Specialty Providers

The state plan currently has two tiers for PCP and Specialty provider copays. Preferred providers include PCPs with shared savings contracts with our present carriers. Preferred specialists are those with better than average quality and efficiency metrics.

Vendors bidding on this proposal are expected to seamlessly coordinate with all of the State's above mentioned vendor partners.

Please be mindful that this RFP covers medical services only.

1.2 Current Medical Plans:

Point of Service ("POS") – Currently the State offers three POS plans. All of the POS plans have provider options with national networks; the UnitedHealthcare/Oxford Freedom Select plan, the Anthem State BlueCare POS plan, and the Anthem State Preferred POS plan.

Within the POS option, each time medical services are required, employees elect whether to access a network provider (and are subject to coinsurance and benefit limits for some services), or access a non-network provider (and receive lower levels of plan benefits). Note that the POS plans provide open access to employees and do NOT require a referral to access network specialists.

Point of Enrollment ("POE") – This option operates as a typical "lock-in" Health Maintenance Organization ("HMO"). That is, benefits are only available if care is rendered by a network provider or authorized by the Health Plan. Note that the POE plans do NOT require a referral to access network specialists. The POE plan offerings are provided through Anthem (using the same network that supports the State Blue Care POS plan) and United Healthcare/Oxford.

Point of Enrollment Gated ("POE-G") – This option operates as a typical "lock-in" Health Maintenance Organization ("HMO") with a gatekeeper. That is, benefits are only available if care is rendered by a network provider or authorized by the Health Plan. Note that the POE- G plans DO require a referral to access network specialists. The POE-G plan offerings are provided through Anthem (using the same network that supports the State Blue Care POS plan) and United Healthcare/Oxford.

Out-of-Area ("OOA") – This option currently consists of a preferred provider organizations ("PPO") available to employees and retirees who permanently reside outside of the carrier's regional coverage area. This plan is provided through Anthem and UnitedHealthcare/Oxford. Anthem provides national access for this plan by utilizing the Blue Cross/Blue Shield network. United offers national network access through its established Choice Plus national network. This plan is closed to new membership.

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The plans are available to active employees and non-Medicare eligible retired members. All medical plans are currently self-insured and the State does not purchase any stop-loss coverage.

The State’s recent active employees and retirees’ open enrollment planners provide eligibility guidelines, benefit summaries, an illustration of employee contributions and an illustration of differences in the breadth of the current networks. You may find the planners and additional benefits information on the State’s web site at: <http://www.osc.ct.gov/benefits.htm>

See the “Benefit Summaries” appendix for additional detail on each medical plan.

The State may consider expanding plan options in the future; thus, a successful bidder would be expected to administer any new plan designs that labor and management agree to offer to state employees, retirees or Partnership plan members.

In addition, the State seeks suggestions from vendors as to whether alternative benefit approaches might improve the covered population’s overall health without increasing the cost to the State. Bidders are encouraged to provide bids for alternative services to be added to the plan. Keep in mind that changes in benefits will need to conform to the current State Employee Bargaining Agent Coalition (SEBAC) requirements.

1.3 RFP Objective

The objective of this RFP is to obtain bids for medical plans that duplicate the current medical benefits in a cost-effective manner, match current benefit designs, and provide high quality service to covered employees, retirees, and their dependents through a robust network of providers with the following goals:

To efficiently and effectively administer existing and planned programs and design elements in order to improve the quality of care provided to plan participants and reduce total plan costs;

To engage a partner with the capacity and willingness to provide the necessary claims processing flexibility and contract reimbursement transparency (limited to the state) that will allow the state to effectively move forward with its objectives of expanding bundled payments in the state along with complimentary total cost of care reimbursement policies that better align the incentives of state plan participants, the state as a payer and health care providers.

To engage a partner with the capacity and creativity to help advance labor, and management, and the plan administration’s ongoing efforts incorporate design and payment changes that improve medical outcomes and reduce cost.

1.4 Planned Schedule of RFP Activities

It is the State’s intention to comply with the following schedule:

Date	Activity
September 24, 2019	Release RFP

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September 30, 2019	Intent to Bid Form and NDA Deadline by 2:00 PM EST
October 4, 2019	Vendor Question Deadline by 2:00 PM EST
October 11, 2019	Vendor Questions Answered
October 16, 2019	Electronic Proposals Posted to Proposal Tech by 2:00 PM EST
October 18, 2019	Hard Copy Proposals Due by 2:00 PM EST
Week of December 2, 2019	Finalist Interviews (if Necessary)
Week of December 9, 2019	Best and Final Offer
December 20, 2019	Contract Awarded
January 1, 2020	Begin Implementation
July 1, 2020	Effective Date for Contract

- These dates represent a tentative schedule of events. The State reserves the right to modify these dates at any time, with appropriate notice to prospective bidders.
- This RFP does not commit the State to award a contract. The State reserves the right to reject all proposals, and at its discretion, may withdraw or amend this RFP at any time.
- The State may revise and amend the RFP prior to the due date for the proposal. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.
- The State reserves the right to reject any and all proposals received, for specific reasons, which include, but are not limited to, non-compliance with RFP requirements.
- Responses to this RFP will be the primary source of information used in the evaluation process. Each Vendor is requested and advised to be as complete as possible in its response. The State reserves the right to contact any bidder to clarify any response or make a presentation.

1.5 Instructions for Submitting Offers

Detailed instructions for the completion and submission of your proposal will be found in the electronic RFP (eRFP) on ProposalTech. ProposalTech will be available to assist you with technical aspects of utilizing the system.

All sections must be answered completely and, as outlined in the RFP, using ProposalTech. It is not acceptable to use the term "See Attached" as a response to any of the questions, fee quotation forms, plan or network comparisons. Such a response may jeopardize your chances for consideration.

Final submissions must be posted with ProposalTech at www.proposaltech.com before the due date and time cited. Access to the eRFP will be locked after that time. Vendors will not be able to post or change their responses. Late proposals will not be considered.

The State reserves the right to ask Vendors follow-up questions through ProposalTech as may be necessary to fully evaluate bidder capabilities.

1.6 Intent to Bid and NDA

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By September 30, 2019, please email the Intent to Bid form (contained in Section V) to the solicitation contact, Ms. Emily Peters, at EPeters@segalco.com and state whether you intend to bid. By September 30, 2019, please email the NDA to Ms. Emily Peters at EPeters@segalco.com. The Intent to Bid form and the NDA are included at the back of this RFP and are posted to ProposalTech. Upon receipt of the Intent to Bid and fully executed NDA, the State's healthcare consultant, Segal Consulting, will provide vendors with detailed claims data and other information to be used in responding to the RFP.

Please note that although Intent to Bid form and NDA will be provided on the ProposalTech system, completed and signed Intent to Bid Forms and NDAs must be emailed to the appropriate parties described above and NOT posted to the ProposalTech site.

Attached Document(s): [SOC A - Intent to Bid Form \(1\).DOCX](#), [SOC B - Non-Disclosure Agreement \(1\).DOCX](#)

1.7 Vendor Questions

Any questions regarding content should be submitted directly to Segal Consulting using the "Ask Questions" feature on the main RFP page by the deadline of **2:00 P.M. (EST) on October 4, 2019**. Questions from any Vendor that is considering a response to this RFP will be answered. Questions via email or telephone will not be accepted. The State reserves the right to provide a combined answer to similar questions. Any and all questions and answers to this RFP will be posted by **October 11, 2019** on ProposalTech and the OSC website at <http://www.osc.ct.gov/vendor/index.html>.

Questions regarding technical issues with the website should be directed to ProposalTech, by calling (877) 211-8316, ext. #4, and asking for support.

1.8 Proposal Submission

All electronic proposals must be uploaded to ProposalTech by 2:00 P.M. (EST), October 16, 2019 in order to be considered. Proposals posted later than the time and date specified will not be considered. If you choose not to offer a proposal, please confirm this in writing with the specific reasons for your declination.

All hard copy proposals must be received by 2:00 P.M. (EST), October 18, 2019 in order to be considered. Proposals received later than the time and date specified will not be considered.

We ask that your proposals limit the amount of materials submitted in paper form. We would expect large bulky printouts, such as geo-access reports, marketing materials, provider lists, etc., to be included on the thumb drive but not included as paper copies. Written materials should be printed double-sided where possible.

In the event of a discrepancy/conflict between the ProposalTech submission and the hard copy version, the ProposalTech version will take precedence. In the event of a power failure or similar occurrence, the hard copy version will be used. In the event a document or section is omitted from the ProposalTech version of the Vendor's response, OSC reserves the right to accept the omitted document or section, if included, in the hard copy version. **All documents, including those related to the Cost Proposal, must remain in their native format.**

Each Vendor must submit one original, one unbound, plus 1 copy of its response in a sealed package upon which a clear indication has been made of the RFP reference title and the date and time the proposal is submitted. Each Vendor shall also submit two copies of its complete response on a thumb drive.

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Any Vendor that submits trade secrets or confidential commercial or financial information must also provide one copy of its RFP response in a thumb drive from which all trade secrets and confidential data have been redacted and which may be disclosed without objection in the event that the State receives a FOIA request for its proposal.

The package should be delivered to:

STATE OF CONNECTICUT

OFFICE OF the State COMPTROLLER

Attention: Steven Cosgrove, RFP – Medical

Administrative Services Division

55 Elm Street, Second Floor

Hartford, CT 06106

1.9 Evaluation of Proposals

Note: These are not listed in order of importance.

1. Vendor's experience with and ability to provide required services.
2. Conformity with specifications.
3. Proposed cost: (provider discounts, administrative costs, fees at risk and guarantees, demonstration of robust approach to control costs, robust fraud, waste and abuse prevention systems).
4. Effectiveness of care: carrier's commitment to improving quality of care and patient outcomes as evidenced by value based and ACO contracting, development of infrastructure sufficient to support these initiatives, ability to demonstrate results, ability to provide continuity of care during contract period).
5. Availability and competence of personnel and evidence of appropriate staffing and training.
6. Robust basic member support services that demonstrate superior member experience via call center, member portal and mobile application, as well as additional member support services including health concierge and navigation services.
7. Adequacy of vendor's network with comprehensive access to healthcare providers (sufficient coverage by general, specialist and pediatric physicians and facilities, average wait times for appointments, number of physicians accepting new patients, willingness to expand network, as needed). Tiered networks will be considered as well.
8. Demonstration of a robust provider panel for mental and behavioral health, and treatment for substance abuse (and willingness to expand network as needed), including telemedicine.
9. Sufficiency of Eligibility Management, Payment and Billing Systems, Customer Service, Flexibility, References, Reporting Capability, Member Services, and Quality Assurance Programs.

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10. Implementation and Communications Plan (workability of transition and implementation schedule; efficiency and fairness of appeals process, sufficiency of member communication programs and systems, assistance with distribution of benefit descriptions, educational materials, notices required by ACA and other federal laws).
11. Information Services and Reporting: Ability to exchange HEP-related claims and other data with State's data warehouse provider and the State's healthcare consultant and other healthcare vendors, availability of standard reports and ad hoc reporting functionality; willingness to work cooperatively with State's other healthcare vendors, and sufficiency of infrastructure to support population health management and improve quality of care and health outcomes.
12. Ability to administer the State's specific benefits design and current programs including COE, Health Advocate Rewards, tiered provider and Site of Service programs, as well as the ability to integrate and coordinate with the State's existing vendor partners and ability and willingness to share the necessary data.
13. Capacity and willingness to share data needed by State to fulfill its objectives, provide the necessary claims processing flexibility and contract reimbursement transparency (limited to the state) that will allow the state to effectively move forward with expanding bundled payments in the state along with complementary total cost of care reimbursement policies that better align the incentives of state plan participants, the state as a payer and health care providers.
14. Demonstration of Vendor's commitment to affirmative action by full compliance with the regulations of the Commission on Human Rights and Opportunities.
15. Willingness to accept the terms and conditions of the State's proposed contract.
16. Commitment to transparency.
17. At the option of the review committee, Vendor's oral interview.

1.10 Contract Period

The State of Connecticut is seeking a contract-effective date commencing July 1, 2020. Proposals should include fees that are guaranteed for a period of no less than three-years beginning July 1, 2020 through June 30, 2023. There will also be the potential for two one-year extensions. Your proposal should provide pricing guarantees for three-years, with the potential for two one-year extensions. The template that should be used for your financial terms is attached to this RFP.

1.11 Restriction on Contact with State Personnel

Except as called for in this RFP, from the date of release of this RFP until the right to negotiate a contract is awarded as a result of this RFP, any communications with personnel employed by the Comptroller's Office, members of the Health Care Cost Containment Committee, and RFP committee members about the RFP until selection of the successor bidders are prohibited. All communications must be directed to Ms. Emily Peters at EPeters@segalco.com. For violation of this provision, the State reserves the right to reject the proposal of the violator.

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1.12 Conflict of Interest

The Vendor shall certify in writing that no relationship exists between the Vendor and the State of Connecticut that interferes with fair competition or is a conflict of interest, and no relationship exists between the Vendor and another person or organization that constitutes a conflict of interest with respect to any State contract. Any successful Vendor must execute a contract and grant disclosure and certification form.

The Vendor shall provide assurances that it presently has no interest and shall not acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder. The Vendor shall also provide assurances that no person having any such known interests shall be employed during the performance of this contract.

1.13 Governing Law

The contract shall be governed in all respects by the laws of the State of Connecticut.

1.14 Verification of Accuracy

1. Your response must designate the individual responsible for coordinating proposal responses and for binding the company to the responses to this RFP.
2. Your response must designate the chief actuary or independent actuary retained by the Proposer who certifies the method used to determine and report requested discount information.
3. Your response must designate proposer’s Medical Director or Chief Medical Officer.

	Proposal Response Coordinator	Chief Actuary/Independent Actuary	Medical Director/Chief Medical Officer
Name	20 words.	20 words.	20 words.
Phone #	20 words.	20 words.	20 words.
Company	20 words.	N/A	N/A
Title	20 words.	20 words.	20 words.

1.15 Terms and Conditions

Contractors responding to this RFP must be willing to adhere to the following conditions and must affirmatively state their adherence to these requirements with a transmittal letter appended to their proposal response.

1. **Acceptance or Rejection by the State**—The State reserves the right to accept or reject any or all proposals submitted for consideration. All proposals will be kept sealed and safe until the deadline for submission has passed. By responding to this procurement, applicants agree to accept the Comptroller’s determinations as final.
2. **Conformance with Statutes**—Any contract awarded as a result of this RFP must be in full conformance with statutory requirements of the State of Connecticut and the federal government.
3. **Ownership of Proposals**—All proposals submitted in response to this RFP are to be the sole property of the State and will be subject to the applicable Freedom of Information provisions of Conn.Gen.Stat. §§1-200 et seq. Any proposer that submits matter that it in good faith determines to contain trade secrets or confidential commercial or financial information must mark such materials as “CONFIDENTIAL” and provide two redacted copies of its RFP response on a thumb

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- drive, which may be disclosed without objection in the event a FOIA request is made for its proposal.
4. **Ownership of Subsequent Products**—Any product, whether acceptable or unacceptable, developed under a contract award as a result of this RFP is to be the sole property of the State of Connecticut, unless explicitly stated otherwise in the RFP or contract.
 5. **Communication Blackout Period**—Except as called for in this RFP, contractors may not communicate about the RFP with any of the following: the Healthcare Policy & Benefit Services Division within the OSC or members of the HCCCC until the successful bidder(s) are selected. No Contractor or Contractor's representative may contact an employee of the State or member of the HCCCC or their representatives regarding their proposal until final selections have been made. Until such time as final selections are made, any such contact will be considered collusion under the "Terms and Conditions" herein and may be grounds for disqualification of the Contractor's proposal.
 6. **Notice of Intent to Respond**—The notice of intent to respond and NDA (Attachments A and B, respectively) will be due to EPeters@segalco.com by 2:00 P.M. on September 30, 2019. In the notice, the Contractor must provide an email address to receive information about the RFP process, including data, answers to questions submitted by other potential contractors, requests for clarification and other matters about the selection process.
 7. **Availability of Work Papers**—All work papers and data used in the process of performing this project must be available for inspection by the State of Connecticut Auditors of Public Accounts for a period of three (3) years or until audited.
 8. **Timing and Sequence**—All timing and sequence of events resulting from this RFP will ultimately be determined by the State. Late responses may or may not be considered, and it will be left to the Comptroller's discretion whether to accept or reject late responses.
 9. **Stability of Proposed Prices**—Any price offerings from Contractors must be valid for a period of one hundred eighty (180) days from the due date of the Contractor proposals.
 10. **Oral Agreements**—Any alleged oral agreement or arrangement made by a Contractor with any agency or employee will be superseded by the written agreement.
 11. **Amending or Canceling Requests**—The State reserves the right to amend or to cancel this RFP prior to the due date and time, if such action is deemed to be in the best interest of the State.
 12. **Rejection for Default or Misrepresentation**—The State reserves the right to reject the proposal of any Contractor that is in default of any prior contract or for misrepresentation.
 13. **State's Clerical Errors in Awards**—The State reserves the right to correct inaccurate awards resulting from its clerical errors.
 14. **Rejection of Qualified Proposals**—Proposals are subject to rejection in whole or in part if they limit or modify any of the terms and conditions and/or specifications of the RFP.
 15. **Contractor Presentation of Supporting Evidence**—A Contractor, if requested, must be prepared to present evidence of experience, ability, service facilities and financial standing necessary to satisfactorily meet the requirements set forth or implied in the proposal.
 16. **Changes to Proposal**—No additions or changes to the original proposal will be allowed after submittal. However, OSC reserves the right to seek clarification of a response.
 17. **Expenses Incurred**—the State will not reimburse any Contractor for any costs or expenses incurred in preparing proposals or in any other connection with the RFP, including travel expenses relating to an oral presentation. All expenses incurred by the Contractor in preparing and submitting proposals are the sole responsibility of the Contractor.
 18. **Collusion**—By responding to this RFP, the Contractor implicitly states that the proposal is not made in connection with any competing Contractor submitting a separate response to the RFP, and is in all respects fair and without collusion or fraud. It is further implied that the Contractor did not participate in the RFP development process, had no knowledge of the specific contents of the

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RFP prior to its issuance, and that no employee of the agency participated directly or indirectly in the Contractor's proposal preparation.

19. **Conformance to Instructions**—All responses to the RFP must conform to the instructions herein. Failure to provide any required information, provide the required number of copies, meet deadlines, answer all questions, follow the required format, or failure to comply with any other requirements of this RFP may be considered appropriate cause for rejection of the response.
20. **Appearances**—In some cases, Contractors may be asked to appear to give demonstrations, interviews, presentations or further explanation to the RFP's screening committee.
21. **Standard Contract and Conditions**—The Contractor must accept the State's standard contract language and conditions. See Standard Contract and Conditions. Attachment C.
22. **Entire Agreement**—The contract will represent the entire agreement between the Contractor and the State and will supersede all prior negotiations, representations or agreements, alleged or made, between the parties. The State shall assume no liability for payment of services under the terms of the contract until the successful Contractor is notified that the contract has been accepted and approved by the Office of the State Comptroller and by the Office of the Attorney General. The contract may only be amended by means of a written signed agreement by the Office of the State Comptroller, the Contractor, and the Office of the Attorney General.
23. **Rights Reserved to the State**—the State reserves the right to award in part, to reject any and all proposals in whole or in part, to waive technical defects, irregularities and omissions if, in its judgment, the best interest of the State will be served.
24. **Receipt of Summary of State Ethics Laws.** The Contractor must acknowledge that is has received a summary of State Ethics Laws by submitting a signed receipt with its bid. **See Attachments D and E hereto.**

Attached Document(s): [SOC - D Contractors Guide to the Code of Ethics \(rev Jan2019\).PDF](#), [SOC - E OPM Ethics Form 6 \(Final 9-15-11\).DOCX](#)

1.16 Standard Contract Terms and Conditions

Be advised that the State has certain contract requirements. Contractors responding to this RFP must be willing to adhere to the following contract requirements and must affirmatively state their adherence to these terms and conditions with a transmittal letter appended to their proposal response.

Attached as Attachment C is a sample contract containing standard terms and conditions. The Contractor must agree that the contract shall be governed by, construed, and enforced in accordance with the laws and court decisions of the State of Connecticut without giving effect to its principles of conflicts of laws. Under no circumstances may a State contract contain limited liability and/or binding arbitration provisions. The State may not indemnify a Contractor or waive its sovereign immunity.

At all times, Contractor shall utilize approved, qualified personnel necessary to perform the services under this Agreement. If at any time the State in its sole discretion determines that the personnel/staff assigned to perform the services under this agreement is incompetent, dishonest or uncooperative, State reserves the right to request that Contractor reassign personnel/staff and arrange for an employee(s) or subcontractor(s) satisfactory to State to provide the services otherwise performable by the Contractor hereunder.

Contractor shall review any requests by State to reassign personnel/staff. In requesting such reassignment of personnel/staff, State shall give thirty days (30) notice to Contractor of State's desire for such reassignment. Contractor will then have fifteen (15) days to investigate the situation and attempt, if it so desires, to resolve the situation to the mutual satisfaction of the parties. Should the parties not reach a mutual resolution, then fifteen (15) days thereafter, or thirty (30) days from the date of the notice of reassignment, the State may terminate this agreement by providing written notice.

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Contractor shall advise the State promptly, in writing, of any labor related occurrence known to Contractor involving Contractor's employees, which may reasonably be expected to affect Contractor's performance of services under this agreement. Notwithstanding such occurrence, the Contractor shall at all times assign competent personnel/staff to perform the services contracted for under this agreement.

Attached Document(s): [SOC_C - Std. Terms and Conditions.DOCX](#)

1.17 Additional Procurement Requirements

The Connecticut Department of Administrative Services ("DAS") has implemented a requirement that all firms seeking to do business with the State create a business profile on the DAS Business Network ("BizNet") system. BizNet eliminates certain redundancies, such as the requirement to complete and submit forms even though the forms had been recently submitted in response to another Request for Proposals. In addition to eliminating redundancy, BizNet has automated the completion and submission of required Ethics Affidavits and Non Discrimination forms. Firms must now upload these forms electronically to their BizNet account and update them on an annual basis, rather than submitting paper copies with each proposal. Firms will have the ability to view, verify and update their information by logging in to their BizNet account, prior to submitting responses to an RFP.

Additional required forms as described below must be submitted to or be on file with the BizNet system by the deadline for submission of proposals. Paper or electronic copies need not be provided with the submission to the Comptroller's office.

Create an account on BizNet by using the following link:

<https://www.biznet.ct.gov/AccountMaint/Login.aspx>.

Once your firm creates an account, login and select "CT Procurement" and then "Company Information" for access. If you experience difficulty establishing or otherwise managing your firm's account, please call DAS at 860-713-5095.

The following forms must be completed and uploaded to BizNet in accordance with the following instructions:

Required Forms

Follow instructions for submission of the following:

- a) Agency Vendor Form (SP-26NB), available at: [http://das.ct.gov/Purchase/Info/Vendor_Profile_Form_\(SP-26NB\).pdf](http://das.ct.gov/Purchase/Info/Vendor_Profile_Form_(SP-26NB).pdf)
- b) W-9 Form, available at: <http://www.irs.gov/pub/irs-pdf/fw9.pdf>

Ethics Certifications

The following Ethics Forms must be signed, dated, notarized, uploaded or updated on BizNet. To obtain these forms, you must login to BizNet and follow the instructions referenced above.

OPM Ethics Form 1: Gift & Campaign Contribution Certification;

OPM Ethics Form 5: Consulting Agreement Affidavit:

OPM Ethics Form 6: Affirmation of Receipt of State Ethics Laws Summary

OPM Ethics Form 7: Iran Certification

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For information on how to complete these forms, please access the Office of Policy and Management website by using the following link:

http://www.ct.gov/opm/cwp/view.asp?a=2982&q=386038&opmNAV_GID=1806

Affirmative Action and Nondiscrimination

Choose one (1) of the forms listed below that applies to your business. Complete and upload or update the form on BizNet annually. To obtain a copy of these forms, you must login to BizNet and follow the instructions referenced above.

Form A: Representation by Individual (Regardless of Value); or

Form B: Representation by Entity (Valued at \$50,000 or less); or

Form C: Affidavit by Entity (Valued at \$50,000 or more); or

Form D: New Resolution by Entity; or

Form E: Prior Resolution by Entity

For information on how to complete these forms, please access the Office of Policy and Management website by using the following link:

http://www.ct.gov/opm/cwp/view.asp?a=2982&q=390928&opmNAV_GID=1806

Commission on Human Rights and Opportunities ("CHRO") Workplace Analysis Affirmative Action Report/Employment Information Form.

The CHRO Workplace Analysis Affirmative Action Report/Employment Information must be completed in BizNet and updated as necessary. You must login to BizNet and follow the Instructions referenced above. For information on how to complete these forms you may contact Diane Comeau at Diane.Comeau@ct.gov for assistance.

For information about how to upload the Ethics Affidavits and Non-Discrimination forms please access the following page. <http://das.ct.gov/images/1090/Upload%20Instructions.pdf>.

Affirmative Action. The proposal must include a summary of the Contractor's experience with affirmative action including a summary of the Contractor's affirmative action plan and the Contractor's affirmative action policy statement.

Regulations of Connecticut State Agencies Section 46a-68j-30(10) require agencies to consider the following factors when awarding a contract that is subject to contract compliance requirements:

The Contractor's success in implementing an affirmative action plan;

The Contractor's success in developing an apprenticeship program complying with Section 46a-68-1 to 46a-68-17 of the Connecticut General Statutes, inclusive;

The Contractor's promise to develop and implement a successful affirmative action plan;

the Contractor's submission of employment statistics contained in the "Workforce Analysis Affirmative Action Report," indicating that the composition of its work force is at or near parity when compared to the racial and sexual composition of the work force in the relevant labor market area; and

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The Contractor's promise to set aside a portion of the contract for legitimate small Contractors and minority business enterprises, where applicable (See C.G.S. §32-9e).

The State of Connecticut's Contract Compliance Forms applicable to State contracts are available at <http://www.ct.gov/chro/cwp/view.asp?a=2525&Q=315900>, please click on the four forms indicated below to download the pdf files from the CHRO web page:

Notification to Vendors

This document gives notice that the contract to be awarded is subject to the contract compliance requirements mandated by State statutes and regulations.

Workforce Analysis Affirmative Action Report-State Contractors

This employment information form is used to report the racial and sexual composition of a firm's or corporation's workplace. The form must be completed by the Contractor and submitted with the proposal.

Affidavit for Certification of Subcontractors as Minority Business Enterprises

Upon award of a contract, this form is used to document the good faith efforts of a Contractor to include minority business enterprises as subcontractors (including suppliers) on the State contract

Contract Compliance Notice Poster

This notice concerns the prohibition of discrimination in employment practices. Upon award of a State contract, the notice must be posted by the Contractor in conspicuous places accessible to all employees and applicants for employment. More information about the State of Connecticut's Contract Compliance requirements is available on the Commission on Human Rights and Opportunities' web site at www.state.ct.us/chro under "Contract Compliance."

Your proposal should confirm you have downloaded, completed, and submitted all of the procurement documents listed above to BizNet. If not, please explain.

Authorized Agent

An authorized agent for the Contractor with authority to negotiate and contractually bind the Contractor must sign the proposal; such individual's title, address, and telephone number must also be provided.

Freedom of Information

All materials submitted in connection with this RFP are subject to the terms of the State of Connecticut Freedom of Information Act (FOIA), Conn.Gen.Stat. §§1-201 et seq. and all rules, regulations and interpretations resulting therefrom. Due regard will be given for the protection of proprietary information contained in a vendor's proposal. Each vendor should identify particular sentences, paragraphs, pages or sections in its response which it in good faith believes to be exempt from disclosure under FOIA by marking each as "CONFIDENTIAL". It will not be sufficient for vendors to state in general terms that the entire proposal is proprietary in nature and therefore not subject to release to third parties. (See instructions below on submitting a redacted thumb drive with your response.)

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2 MEDICAL PLAN CONFIRMATIONS

Below are the specific confirmations for submitting a Medical proposal. By checking "Confirmed", Bidder represents the proposal submitted adheres to these confirmations, unless otherwise noted in the proposal. **Failure to agree to any of these confirmations may result in disqualification of proposal.** If a Bidder takes exception to any of these confirmations, it must be so noted in the Bid Exceptions and Deviations Document (Attachment F) of their proposal response. These confirmations will also explicitly apply to any subcontractors used by the Vendor to deliver services to the State.

2.1 Confirm that you are licensed to do business in the State of Connecticut.

Single, Radio group.

1: Confirmed,
2: Not confirmed: [500 words]

2.2 Completion of this proposal confirms your ability to duplicate requested benefits. If you are unable to meet all requirements, variations should be clearly reported in the Bid Exceptions and Deviations Document. Completion in whole or in part will also act as confirmation of the accuracy of the data provided in your proposal.

Single, Radio group.

1: Confirmed,
2: Not confirmed: [500 words]

2.3 Confirm that you will have certain providers removed from the Medical Network, at the State' request for such instances as evidence of fraud, waste and abuse or placement on the Office of Inspector General (OIG) Exclusions List, evidence of poor member health outcomes/management, etc.

Single, Radio group.

1: Confirmed,
2: Not confirmed: [500 words]

2.4 Confirm that proposed fees include transfer of claim accumulation information (deductible, out-of-pocket maximums, etc.) on an electronic file or media to any subsequent Administrator at no charge.

Single, Radio group.

1: Confirmed,
2: Not confirmed: [500 words]

2.5 Confirm that proposed fees include payment of "run out" claims at no extra charge. Run-out administration will be the responsibility of the then incumbent Administrator.

Single, Radio group.

1: Confirmed,
2: Not confirmed: [500 words]

2.6 Confirm that there will be no minimum participation requirements.

Single, Radio group.

1: Confirmed,
2: Not confirmed: [500 words]

2.7 Confirm you will comply with any independent auditing or claims review firm employed by the State in providing required financial information, claim information and claim documents for claims audits and/or review.

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Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed: [500 words]

2.8 Confirm you agree to pay the State 100% of any overpayments made by the State as determined from an audit no later than 30 days after both parties have agreed to the recoveries, subject to a compounding interest penalty of 1% per month.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed: [500 words]

2.9 Confirm that you will be responsible for defending any litigation concerning erroneous claims administration.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed: [500 words]

2.10 The Vendor will be required to interface with the following organizations below. Confirm your agreement with details outlined in the table below.

Attached Document(s): [SOC_G - Eligibility File Feed Requirements.PDF](#), [SOC_H - File Layout Remedy 09-2019.XLSX](#)

Organization	Description of Files	Frequency	File Format	Confirmation	Comments
State	Vendor will receive an initial full eligibility feed and eligibility updates (change file)	At least weekly	Standard HIPAA 834 Benefit Enrollment and Maintenance transaction file layout	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, explain in comments	500 words.
CMSI (chronic condition management) / Conifer (data warehouse)	Vendor to provide a data feed of all medical claims.	Weekly	Mutually agreed upon format	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, explain in comments	500 words.
Highline Health (data management)	Vendor to provide a detailed claims and patient information data feed monthly data feed of all medical claims.	Monthly. Data feed must be provided for the prior month by the 3 rd business day of the current month.	Mutually agreed upon format	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, explain in comments	500 words.
Segal Consulting (health care consultant)	Vendor to provide a detailed claims and patient information data feed monthly data feed of all medical claims.	Monthly. Data feed must be provided for the prior month by the 3 rd business day of the current	Mutually agreed upon format	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, explain in comments	500 words.

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		month.			
Remedy Partners	Vendor to provide an initial claims file and then ongoing files	Real time (For the ongoing file daily is preferred, weekly at a minimum)	Proposers to see SOC_H: File Layout Remedy 09-2019 file attached below	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, explain in comments	500 words.
Carrum Health	TBD	TBD	TBD	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, explain in comments	500 words.
Health Advocates	TBD	TBD	TBD	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, explain in comments	500 words.
CVS Caremark (PBM)	To be discussed	To be discussed	To be discussed	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, explain in comments	500 words.
Cigna (Dental)	To be discussed	To be discussed	To be discussed	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not confirmed, explain in comments	500 words.

2.11 Confirm you will notify the Plan and each affected individual directly if a breach of unsecured protected health information is discovered, as required under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and in accordance with the HIPAA/HITECH Comprehensive Final Rule.

Single, Radio group.

- 1: Confirmed,
2: Not confirmed: [500 words]

2.12 Confirm your willingness and ability to modify claims processing systems in order to administer unique reimbursement schedules and methodologies specific to the state employee plan.

Single, Radio group.

- 1: Confirmed,
2: Not confirmed: [500 words]

2.13 Confirm all out of network services at inpatient hospitals are reimbursed according to fee schedule or UCR. Explain methodology.

Single, Radio group.

- 1: Confirmed,
2: Not confirmed: [500 words]

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3 ADDITIONAL REQUIREMENTS

Below are additional requirements for submitting a Medical proposal. By checking "Confirmed", Vendor represents the proposal submitted adheres to these requirements, unless otherwise noted in the proposal. **Failure to agree to any of these requirements may result in disqualification of proposal.** If a Vendor takes exception to any of these requirements, it must be so noted in the Bid Exceptions and Deviations Document of their proposal response. These requirements will also explicitly apply to any subcontractors used by the Bidder to deliver services to the State.

3.1 General

3.1.1 Vendor will provide all labor, equipment, facilities, supplies, and services as needed/specified.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.1.2 Administration of benefit plans for active and retired State employees and dependents and affiliated groups participating in the program described in Section I:

Vendor must agree to administration of the plan as mutually agreed to by the vendor and the State, with final determination to be made by the State. All operational aspects of the plan must be clearly described and the State must reserve the right to review and audit the operations of the plan.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.1.3 Develop and maintain an employee benefit plan providing benefits as specified by the State. The benefit plans to be offered are described on the State's website at <http://www.osc.ct.gov/stemploy.htm>.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.1.4 Vendor must allow the State to test website structure, pages, and review and approve content for usability as determined by the State; usability concerns must be resolved within two (2) business days.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.1.5 Vendor must agree that all data, records, files and other information relating to the plan belong to the State and are subject to release to the State if the contract is terminated.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.1.6 Vendor must provide a copy of their emergency operations/disaster recovery/business continuity/pandemic flu plan as part of their response to this RFP.

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Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed, please explain: [500 words]

3.1.7 Vendor must provide detailed information on insurance, bonding, and guarantees offered in the event of issues caused by loss of operations due to an emergency or disaster.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed, please explain: [500 words]

3.1.8 Vendor must provide subrogation services.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed, please explain: [500 words]

3.1.9 Vendor must disclose offshore relationships, if any.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed, please explain: [500 words]

3.1.10 Vendor must receive prior approval for all communications to members. This includes all written website, electronic communication including, but not limited to, media advertising and regulatory mailings required under federal and/or state law. During open enrollment periods, all general media advertising in the State of Connecticut media markets must also be approved by the State. Failure to comply will result in a penalty payment of 0.50% of total expenses, no less than \$30,000 and no greater than \$100,000.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed, please explain: [500 words]

3.2 On-line services/Functions

3.2.1 What on-line services/functions will be made available to the State?

	Response	Comments
I. Claims Summary and detail	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not Confirmed, please explain	500 words.
II. Billing History	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not Confirmed, please explain	500 words.
III. Provider Directory	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not Confirmed, please explain	500 words.
IV. Enrollment Summary	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not Confirmed, please explain	500 words.
V. Medical Cost Tracker by Member	<i>Single, Pull-down list.</i>	500 words.

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	1: Confirmed, 2: Not Confirmed, please explain	
VI. Ability to Order New Member Materials	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not Confirmed, please explain	500 words.
VII. Ability to Print Temporary ID Cards	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not Confirmed, please explain	500 words.
VIII. Health Topics/Medical Information	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not Confirmed, please explain	500 words.
IX. COBRA Enrollment	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not Confirmed, please explain	500 words.
X. Special Enrollment	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not Confirmed, please explain	500 words.
XI. Medical Coverage Positions/Coverage Stance (ex. Cochlear Implants)	<i>Single, Pull-down list.</i> 1: Confirmed, 2: Not Confirmed, please explain	500 words.

3.3 Eligibility

3.3.1 Vendor must agree to accept and provide electronic data feeds in the appropriate HIPAA or State defined format on a schedule determined by the State. Currently for active employees and retirees, enrollment data is sent via the HIPAA 834 format. All carriers will receive the identical format and data structure as defined by the State.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed, please explain: [500 words]

3.3.2 Vendor must agree to share data with health benefits administrators and the State's healthcare consultant and actuary, data manager and wellness plan coordinator.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed, please explain: [500 words]

3.3.3 Vendor must agree to accept the eligibility structure as defined by the State.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed, please explain: [500 words]

3.3.4 Enrollment data that does not pass carrier system edits must either be corrected or bypassed by the carrier. The remaining data must be posted without delay. Issues related to errant data must be addressed with the employing agency's benefit staff or the Healthcare Policy and Benefit Services Division as appropriate.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed, please explain: [500 words]

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3.3.5 Vendor must agree to the State-defined Eligibility Periods; award of this contract means that any eligible employee and their dependents will be eligible for coverage.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.3.6 Open enrollment shall be the period announced by the State to allow eligible subscribers to join the plan, change coverage, or add eligible dependents. The open enrollment periods are generally from May 1st to June 1st each year for active employees and retirees.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.3.7 HIPAA Events: members may add, drop or make changes as appropriate if an allowable qualifying event occurs.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.3.8 The vendor must agree to process active and retiree enrollment additions, changes and deletions correctly within seven (7) days of the creation date of the file or information provided by the State. The State will provide a weekly file to report any changes within their enrollment data (to be known as the Change File). This file will include additions, terminations, coverage class changes, changes in dependent enrollment, etc. Towards the end of each month, the State will provide a monthly file to report a snapshot of all current live enrollment data (to be known as the Full File). The Full File is typically not loaded and used for comparative purposes only. After receipt of the monthly Full File, the vendor must reconcile all active employee and retiree enrollment data and report any discrepancies, in a format defined by the State, by the 15th of the next month to the appropriate State agency personnel; aggregate information must be sent to the Healthcare Policy and Benefit Services Division. The State will review the discrepancies and provide feedback appropriate to the condition being reported and make any necessary corrections to State enrollment information.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.3.9 Group Numbers - Department ID, as defined by the State, will substitute for any arbitrary vendor group number that might otherwise be assigned to a State agency or location. More specifically, enrollment and remittance information from the State will include the Department ID as the sole identifier of an employee's location. The vendor may translate the data to accommodate their own systems, however; all communications to and from the State and its data warehouse vendor, whether electronic or otherwise, will refer to the Department ID.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.3.10 The vendor will capture and report the State provided Employee ID (EMPLID) in data stores and data transfers with the State and other state vendors. The member's EMPLID must also be connected to all associated dependents.

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Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.3.11 The vendor will provide the State with online access to their enrollment information in real time.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.3.12 The vendor will agree to certify disability status of dependents turning age 19 and 26.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.3.13 The successful Partnership vendor must agree to process enrollment additions, changes and deletions correctly within seven (7) days of the creation date of the file or submission of information provided by the Partnership Plan groups and to administer the billing of all Partnership premium.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.4 File Exchange Protocol

3.4.1 There are currently two methods for exchanging files with the State's Core-CT system:

- a. The carrier logs into the secure Core-CT Production Supplier Portal via https to download files. The URL is <https://corect.ct.gov:10400/psp/PSPRD/signon.html>

-or-

- b. The carrier logs into the secure Core-CT Axway Server. The URL is <https://sfile.ct.gov/> For those using an automated system Axway has a client available at <http://www.axway.com/productssolutions/securetransport>

Testing Requirements

At least one test cycle must be completed successfully prior to going live employing one of the previously mentioned file transports.

The Core-CT Supplier Portal uses a non-standard port (10400 for Production, 15000 for Test) and that may require action by the carrier's Tech Support area to accomplish this. Vendors must report in their response to this RFP whether they were able to successfully reach the portal sign on page at:

<https://corect.ct.gov:10400/psp/PSPRD/signon.html> or have obtained Axway client software and successfully connected to: <https://sfile.ct.gov/>

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For testing purposes, the link to the TEST supplier portal is:

<https://corect.ct.gov:15000/psp/PSTPR/?cmd=login&languageCd=ENG&>

Additional information for all parties that exchange data with State's Core-CT system is available at:

<http://www.core-ct.state.ct.us/hrint/>

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.5 Network Development, Rental and Management

3.5.1 Vendor must assist with developing a proprietary network, if the State so chooses.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.5.2 Vendor will be responsible for maintaining all provider contracts, terms and conditions, within its claims payment system.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.5.3 Vendor will handle all provider quality issues.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.6 Administrative or Executive Support

3.6.1 Vendor must verify and commit that during the length of the contract, it shall not undertake a major conversion for, or related to, the system used to deliver services to the plan without specific written notice to the State. This does not apply to any program fixes, modifications and enhancements.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.6.2 Vendor must notify the State prior to any changes in vendor's representatives.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.6.3 Vendor must agree to change the assigned vendor's representatives at the State's request.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

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3.7 Performance Standards

3.7.1 Vendor must comply with performance standards as identified in this RFP (examples provided in Performance Standards are provided for illustrative purposes only and may be expanded at the State's option.)

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.8 Audits

3.8.1 Vendor must agree to audits conducted by the State or their chosen auditor and/or legislative audit.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.8.2 Vendor must agree to annually provide a SSAE-16 Report if the State determines there is a need (allowable time will be given to provide this information, if the vendor doesn't currently have a completed or a SAS 70 and any other applicable audits and certifications).

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.8.3 Vendor must agree to make available all provider records to the State or its representatives (e.g. State Auditors, the State's actuary, etc.).

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.8.4 Vendor will guarantee to the State or its appointees the right to reasonable inspection of facilities, equipment, and system support operations to ensure the continued ability of the vendor to support the plan; failure to comply with a reasonable request to inspect will result in a penalty; failure to respond to a finding from an inspection within 30 calendar days will result in a penalty.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.9 Data Requirements

3.9.1 Vendor must agree to provide claims data in the format outlined by the State on a schedule determined by the State.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.9.2 Vendors must agree to provide requested claims, enrollment, and related data to the State's consultant and data manager for inclusion in the State's claims database.

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Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.9.3 Vendor must agree to supply weekly medical claims including procedure and diagnosis codes and payment data to the State or its designated data manager vendor (Currently Conifer).

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.10 Reporting Requirements

3.10.1 Vendor must provide some form of on-line ad hoc reporting capability with full description of the tools available.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.10.2 Vendor must provide reporting based on the divisions defined by the State.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.10.3 Vendor will provide a detailed description of its capability to track and report on telephone services to include categories being monitored; at a minimum, the vendor must provide a monthly report of types of calls, number of calls resolved during the month, phone abandonment rate, and average response times.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.10.4 Vendor must negotiate with the State to develop mutually agreeable reporting formats and deadlines; the State reserves the right to establish formats and deadlines, if negotiations fail.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.10.5 Vendor must provide basic provider background information, cost data, and quality data on a scheduled basis as determined by the State.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.11 Accounting/Actuary Requirements

3.11.1 Vendor must provide a year-end report at the appropriate plan year-end.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

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3.11.2 Vendor will respond to all requests for additional information within a 24-hour period.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.11.3 Vendor will provide a copy of the data dictionary for all fields that are operational in any system proposed. This data dictionary must include the length of the field and a specific description of the data stored in each field.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.12 Privacy and Security

3.12.1 Vendor must comply with HIPAA, PPACA and other federal and/or state mandates to include privacy, security and electronic data transfer requirements.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.12.2 Vendor must describe any breaches, complaints or grievances with regards to protected health information (e.g., security or privacy) for their complete book of business; list the event and resolution in detail.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.12.3 Vendor must disclose any event where its employees have willfully committed acts that compromise member information, regardless of whether it is PHI or not.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

3.12.4 Vendor must describe its HIPAA policies, procedures and training related to quality and provider data.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, please explain: [500 words]

4 REMEDY HEALTH PARTNER REQUIREMENTS

Below are additional requirements for Vendors to work with Remedy Partners on the State's national COE program and Episodes of Care Payment Program. By checking "Confirmed", Vendor represents the proposal submitted adheres to these requirements, unless otherwise noted in the proposal. **Failure to agree to any of these requirements may result in disqualification of proposal.** If a Vendor takes exception to any of these requirements, it must be so noted in the Bid Exceptions and Deviations Document of their proposal response.

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These requirements will also explicitly apply to any subcontractors used by the Bidder to deliver services to the State.

4.1 Data Transfer Requirements

4.1.1 For semi-annual and annual analyses: A complete file with a running 24 months of data, all claims incurred, fully adjudicated with 6 months of run out. This data will be used to facilitate semi-annual reconciliations of the episodes of care program for each participating provider. In addition, the data will also be used to populate pricing transparency tools that are made available to State Employee and Affiliated Plan Members A comprehensive notification of Carrier network fee-for-service contract increases/decreases for all contracted entities and all lines of business to assess any general trends and increases in the Connecticut medical price index.

Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not Confirmed, please explain: [500 words]

4.2 Ongoing Program Implementation of Files From Vendor to Remedy Partners

4.2.1 Claims Data Transfer

1) Vendor to send Claims File to Remedy for processing through the episode of care bundling system.

a) Medical claims

i) Frequency:

(1) One time load of claims with dates of services and paid dates in the three (3) months prior to program live date. This file is needed as close to the live date as possible, but no more than five (5) business days after the program initiates.

(2) Ongoing- daily.

ii) Status: All finalized claims (paid, denied) and all adjustments to finalized claims

b) Pharmacy claims to be provided by current pharmacy vendor

i) Frequency:

(1) One time load of claims paid in the three (3) months prior to program live date.

(2) Ongoing- weekly preferred, monthly at a minimum

ii) Status: All finalized claims (paid, denied) and all adjustments to finalized claims

Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not Confirmed, please explain: [500 words]

4.2.2 Enrollment/Eligibility Data Transfer

1) Vendor to send enrollment/eligibility file.

a) Files used to identify eligible program participants from incoming medical status data from provider systems (HL7, ADT, etc.) for early engagement

b) Frequency:

i) One time load of all members eligible for the program who are effective as of the first date of the program

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- ii) Ongoing Add/Term/Change files- daily
- c) Members attributed to an ACO or other Value Based Payment (VBP) Program should be flagged as such and on-going files should identify any shift in that attribution

Single, Radio group.

- 1: Confirmed, please explain: [500 words] ,
- 2: Not Confirmed, please explain: [500 words]

4.2.3 Provider data

- 1) Vendor to send contracted provider's demographic data to Remedy (file specifications provided)
 - a) Necessary for Remedy EOC contract and program development
 - b) Identify provider participation and associated terms of participation for value based arrangements – i.e. ACO, capitation models, other risk programs
 - c) Frequency:
 - i) One time load of all providers
 - ii) Ongoing Add/Term/Change files- weekly.
- 2) Provide quality of care data and associated detailed specifications for each provider submitting quality data to Vendor.
 - i) One time load of all providers
 - ii) Ongoing for performance evaluation and reconciliation
- 3) Communicate provider contract changes (frequency – quarterly)

Single, Radio group.

- 1: Confirmed, please explain: [500 words] ,
- 2: Not Confirmed, please explain: [500 words]

4.2.4 Pre-Certification/Prior Authorization Data Transfer

- 1) Vendor to send Pre- certification or Prior Authorization records.
 - a) Files used for early identification of episodes of care
 - b) Frequency:
 - i) One time load of all approved authorizations received in the month prior to the live date
 - ii) Ongoing-daily

Single, Radio group.

- 1: Confirmed, please explain: [500 words] ,
- 2: Not Confirmed, please explain: [500 words]

4.3 Remedy Partners to Vendor

4.3.1 Claims Data Transfer

Vendor to accept an enrollee level status Indicator that the enrollee is in an Episode of Care. Used by customer support to field questions, and/or to transfer the call to Health Advocate.

Single, Radio group.

- 1: Confirmed, please explain: [500 words] ,
- 2: Not Confirmed, please explain: [500 words]

4.3.2 Episodes Of Care Reconciliations Data Transfer

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Vendor to receive EOC reconciliations by provider for State Employee Plan Members managed by Vendor to avoid any double counting of gains or losses across VBP programs.

Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not Confirmed, please explain: [500 words]

4.4 Additional Requirements to Support Prospective Payment Program

4.4.1 Vendor to Remedy:

Claims Data Transfer

- 1) Frequency:
 - a) Real-time
- 2) Status: Post adjudicated but pre-paid claims.

Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not Confirmed, please explain: [500 words]

4.4.2 Remedy to Vendor:

Claims Data Transfer

- Vendor to interrupt adjudication and accept a claim line level message Remedy will use the Remedy Bundle Engine to analyze the claim and determine the claim's episode status. Episode of Care (EOC) messaging at the claim line level from Remedy to the payer/partner would occur. Messaging would indicate whether a claim line was a "trigger" for an episode, included in an episode or unrelated to the episode.

Payment request file

If the claim/claim line is a trigger, a funding request would be sent to the Vendor for a predetermined % of the target price. The TPA or payer would disburse the payment to Remedy and Remedy would then make the payment to the appropriate party and accrue the \$ toward the episode target price.

Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not Confirmed, please explain: [500 words]

4.5 Additional Requirements to Support Program

4.5.1 Vendor will warm transfer all provider calls related to the Episodes of Care and COE program to Remedy, and will accept a warm transfer of any provider looking for support on other network issues from Remedy.

Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not Confirmed, please explain: [500 words]

4.5.2 Vendor will warm transfer to Health Advocate all State Employee Plan Member inquiries about the COE and incentives program (successor to the SmartShopper program) and will accept a warm transfer from Health Advocate of a plan member seeking support from Vendor on other issues.

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Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not Confirmed, please explain: [500 words]

4.5.3 Vendor will create a single-sign on process that will result in State Employee Plan members being transferred to the Health Advocate environment for provider searches and other information related to the provider network, the successor program to the SmartShopper program, and the COE Program.

Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not Confirmed, please explain: [500 words]

4.6 Recommended Program Support

4.6.1 Vendor network management and/or contracting staff to actively support Remedy in contracting for Episodes of Care and to explain to their network the interaction between the State EOC program and the Vendor's other VBP arrangements.

Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not Confirmed, please explain: [500 words]

4.6.2 Vendor to report to State any fee schedule increases from any network providers that apply to a book of business other than the State Employee Plan and that are greater than expected, meaning greater than the core Medical Price Index in order for the State to monitor the potential for providers to cost shift to other employers in Connecticut.

Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not Confirmed, please explain: [500 words]

4.6.3 Vendor willingness to encourage their self-insured employers to participate in a similar program as that of the State of CT EOC program, thus increasing the volume of plan members from which EOC contracted providers could benefit.

Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not Confirmed, please explain: [500 words]

4.6.4 Vendor to engage its fully insured book of business in a similar program as that of the State of CT EOC program, thus increasing the volume of plan members from which EOC contracted providers could benefit.

Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not Confirmed, please explain: [500 words]

4.6.5 Vendor network contracting, customer, member and operations leadership to participate in at least quarterly meeting with Remedy to review program stats, potential changes/enhancements to program and Vendor scorecard reflecting compliance with program support requirements.

Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not Confirmed, please explain: [500 words]

4.6.6 Vendor willingness to expand the provider network for selected target providers.

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Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not Confirmed, please explain: [500 words]

5 QUESTIONNAIRE

5.1 COMPANY OVERVIEW

5.1.1 Provide contact information for the individual authorized to answer questions regarding your response to the RFP.

Contact Name	500 words.
Contact Title	500 words.
Address	500 words.
Telephone Number	500 words.
e-Mail Address	500 words.
Company URL (web address)	500 words.

5.1.2 Please complete the following table:

	Response
Year Organization Established	500 words.
Total Lives Covered (2018)	500 words.

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Percent Lives Covered from Top 10 Clients	500 words.
Total Number of Your Organization's Employees (2018)	500 words.
Describe any parent/subsidiary relationship.	1000 words.

5.1.3 Provide the most recent ratings and date of rating for your company by the major rating organizations.

Rating Agency	Rating	Date of Rating
Standard & Poors	10 words.	10 words.
Fitch	10 words.	10 words.
A.M. Best	10 words.	10 words.
Moody's	10 words.	10 words.

5.1.4 Has there been a downgrade in your ratings in the last 2 years?

Single, Radio group.

1: Yes,

2: No: [500 words]

5.1.5 Has your organization recently undergone any workforce realignments and/or experienced recent merger or acquisition activity? If so, please describe. Are there any anticipated changes in ownership or business developments, including but not limited to mergers, stock issues, and the acquisition of new venture capital? Please explain.

500 words.

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5.1.6 Describe any changes in the organizational structure (including, but not limited to demutualization, addition/deletion of claim offices, addition/removal of product lines, and staff reductions) that have occurred in your organization over the last twelve (12) months or are anticipated to occur in the next 24 months.

500 words.

5.1.7 Describe any staff relocations, computer system changes/upgrades, program changes, or telephone system changes in process at this time or proposed within the next 12-24 months.

500 words.

5.1.8 Indicate how many years your organization has been in the business of providing the coverage(s) for which you are submitting a proposal.

Single, Pull-down list.

1: More than 10 years,

2: 5-10 years,

3: 1-4 years

5.1.9 Does your company have any administrative, regulatory, judicial actions or investigations regarding past or current activities? If yes, please explain the nature and current status of the action(s) to the extent possible.

Single, Radio group.

1: Yes: [500 words],

2: No

5.1.10 Please complete the following table:

	Response	Comments
Have you ever failed to complete any work awarded to you? If so, where and why?	Single, Pull-down list. 1: Yes, 2: No, please explain	500 words.
Have you ever defaulted on a contract? If so, where and why?	Single, Pull-down list. 1: Yes, 2: No, please explain	500 words.
Has your firm ever had a contract terminated for cause within the past five years? If yes, provide details.	Single, Pull-down list. 1: Yes, 2: No, please explain	500 words.
Has your firm been named in a lawsuit related to errors and omissions within the past five years? If yes, provide details.	Single, Pull-down list. 1: Yes, 2: No, please explain	500 words.
During the past seven years, has your firm ever filed for protection under the Federal bankruptcy laws? If yes, provide details.	Single, Pull-down list. 1: Yes, 2: No, please	500 words.

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	explain	
Have you ever been fined for a HIPAA violation?	<i>Single, Pull-down list.</i> 1: Yes, 2: No, please explain	<i>500 words.</i>
Are there any other factors or information that could affect your firm’s ability to provide the services being sought about which the State should be aware?	<i>Single, Pull-down list.</i> 1: Yes, 2: No, please explain	<i>500 words.</i>

5.1.11 What fidelity and surety insurance or bond coverage do you carry or would you recommend to protect the State? Specifically, describe the type and amount of the fidelity bond, which would protect the State in the event of a loss. Please provide copies of such policies.

1000 words.

5.1.12 What cyber security insurance do you carry or would you recommend to protect the State? If named a finalist, the State will require that you provide copies of all privacy policies, terms of use protections and any other terms related to cyber security protection. Please note that this applies not only for how you will use and transfer data but also as it relates to employee sites or portal access.

1000 words.

5.1.13 Provide names of all subcontractors along with type of services they will provide, the number of years your firm has utilized the subcontractor, and the contractual relationship between subcontractor and your company. Please use the table provided below.

	Name and Address	Type of Service(s)	Years Utilizing this Contractor	Contractual Relationship
1.	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required
2.	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required
3.	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required
4.	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required
5.	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required	<i>Unlimited.</i> Nothing required

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5.1.14 Confirm that all of your subcontractors are authorized/licensed to do business in Connecticut.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not Confirmed

5.1.15 Indicate your firm's liability insurance limit with regard to errors, omission, negligence, and malpractice. Include in your response the annual dollar limit per occurrence:

1000 words.

5.1.16 Confirm you will provide the last 2 years of your firm's unaudited financial statements.

Single, Pull-down list.

- 1: Confirmed and unaudited financial statements attached,
- 2: Not Confirmed

5.1.17 Do you meet all NAIC, minimum state insurance and managed care organization net worth and reserve requirements?

Single, Radio group.

- 1: Yes,
- 2: No: [500 words] .

5.2 EXPERIENCE

5.2.1 Provide statistics regarding membership that receives medical administration services from your firm. Provide statistics further split as requested in the grid, below.

	Total Group Covered Lives	Group Covered Lives in Connecticut	Total Number of Employer Groups	Public Sector Covered Lives	Number of Public Sector Groups	Number of Clients with 50,000+ Covered Lives
2018	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>
2019	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>

5.2.2 How many new groups with more than 500 covered lives did your organization add effective on or after January 1, 2019?

	2019 New Groups	Total Member Count

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Actives and Early Retirees	<i>Integer.</i>	<i>Integer.</i>
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5.2.3 What percentage of your 2018 total group membership renewed for the 2019 plan year?

	2018 Total Group Member Percentage Renewed
Actives and Early Retirees	<i>Percent.</i>

5.3 BASIC MEMBER SERVICES

5.3.1 Confirm that a specific toll-free number will be made available to members at no additional charge to handle claims or other service issues.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not Confirmed

5.3.2 Confirm this specific toll-free number will be dedicated solely to the State (meaning only members of the State or Partnership Plans can access this line).

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed: [500 words]

5.3.3 Confirm that this toll free number will be answered by a staff member and not a voice recording.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed: [500 words]

5.3.4 Confirm that this toll free number will be offered in languages other than English.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

5.3.5 Confirm that at a minimum, all Vendor staff servicing the State will be available from 9:00 a.m. to 5:00 p.m., EST, Monday through Friday.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed: [500 words]

5.3.6 Confirm the Member Services line will produce performance-reporting specific to the State only.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not Confirmed

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5.3.7 Do members reach a live member service representative (MSR) or an interactive voice response unit (IVR) when calling Member Services?

500 words.

5.3.8 Do members have access to the claims/Member Service group via e-mail or internet? If yes, please specify features available (e-mail, web chat, etc.).

Single, Radio group.

1: Yes [500 words] ,

2: No

5.3.9 How are calls "after hours" of operation handled? Is there a voicemail system or capability for caller to leave messages after normal business hours?

Single, Radio group.

1: Voice Mail,

2: No Service,

3: Full Service (24/7),

4: Some Extended hours for calls,

5: Other, please specify: [500 words]

5.3.10 Provide the geographic location of the Member Service unit(s) that will be servicing the State's members. Will this service be outsourced? If so, provide the name of the outsourcer.

500 words.

5.3.11 Using most recent year-end data complete the table below for the office that would be handling State calls:

	Target	Actual 2018 year end results
Call Volume (calls/day)	N/A	500 words.
Call Abandon Rate (%)	500 words.	500 words.
Average Speed of Answer (in seconds)	500 words.	500 words.
Average wait time (in seconds)	500 words.	500 words.

5.3.12 Check all items below, which pertain to calls handled by the MSR:

Multi, Checkboxes.

1: All calls are recorded,

2: MSRs document all calls,

3: MSRs can make adjustments to claims during a call,

4: Calls are documented verbatim,

5: Calls are documented in summarization,

6: Other, please explain [500 words]

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5.3.13 Can the MSRs access claims status online real-time?

Single, Radio group.

1: Yes,

2: No: [500 words]

5.3.14 Can MSRs make adjustments to claims during a call in real-time?

Single, Pull-down list.

1: Yes,

2: No

5.3.15 Describe the escalation process for Member Service satisfaction and complaints.

1000 words.

5.3.16 What are the education and experience qualifications your organization requires of the MSR staff that will serve the State's members?

1000 words.

5.3.17 Describe the process in which staff supporting the State will be trained on their account and benefits.

1000 words.

5.3.18 Do your web-based and app-based products comply with all current and known future security and HIPAA requirements for both aggregate and individual transactions?

Single, Pull-down list.

1: Yes,

2: No

5.3.19 Describe your member website and member smartphone app (if applicable) capabilities including whether your member website and smartphone app include the following:

a. Accurate provider directory and provider search (physician, hospital, pharmacy, and ancillary providers)

b. Ability to make a doctor's appointment online

c. Physician and hospital quality and outcomes data

d. Physician and hospital pricing data by procedure by provider

e. Physician and hospital reviews from other members

f. Treatment cost estimator

g. Information about diseases and conditions

h. Ability to see a summary of the State's plan design and review the State's SPD

i. Ability to review the State's appeals process and file an appeal online

j. Ability to review the waste, fraud and abuse notification process

k. Contact information for the State, its other vendors, and links to their websites

l. On-line access to forms

m. Ability to review claims payment status online

n. Ability to review a history of claims payments (medical and pharmacy), including deductible status, out-of-pocket maximum status

o. Ability to review or print out EOBs and a history of claims payments

p. Ability to print ID cards and request replacement cards

q. Dependent information

r. Ability to contact member services online

s. Ability to access telemedicine services

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Unlimited.

5.3.20 Describe the web and smartphone apps planned for deployment in future years?

1000 words.

5.3.21 Confirm that you will include the State's logo throughout your portal and that online tools can be customized, as requested by the State.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

5.3.22 Complete the table below regarding ID Cards:

	Response	Comments
a. Confirm that you will issue a member ID card and mail, via surface mail, to covered Members within ten (10) business days following the enrollment period.	<i>Single, Pull-down list.</i> 1: Confirmed, explain in comments, 2: Not confirmed, explain in comments	<i>500 words.</i>
b. Confirm that all State covered members will have a valid ID card in hand prior to July 1, 2020.	<i>Single, Pull-down list.</i> 1: Confirmed, explain in comments, 2: Not confirmed, explain in comments	<i>500 words.</i>
c. Confirm that you will re-issue the member ID card within five (5) business days of notification that a member has lost a card, or for any reason that results in a change to the information disclosed on the member ID card.	<i>Single, Pull-down list.</i> 1: Confirmed, explain in comments, 2: Not confirmed, explain in comments	<i>500 words.</i>
d. Confirm extra ID cards will be available for a dependent child away from home attending school or residing out of area.	<i>Single, Pull-down list.</i> 1: Confirmed, explain in comments, 2: Not confirmed, explain in comments	<i>500 words.</i>
e. Indicate how many ID cards you will mail to subscribers who have family coverage, at no additional charge.	<i>500 words.</i>	
f. Confirm members may request new ID cards and print temporary ID cards from your website.	<i>Single, Pull-down list.</i> 1: Confirmed, explain in comments, 2: Not confirmed,	<i>500 words.</i>

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	explain in comments
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5.3.23 Provide the most recent results of your annual Medical Plan survey.

500 words.

5.3.24 Confirm you are compliant with the Internal Claims and Appeals and External Review requirements under the Affordable Care Act (ACA).

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed: [500 words]

5.3.25 If the State were to offer health advocacy and navigation services through a separate concierge service vendor, describe how you would collaborate with an outside concierge service vendor to coordinate services, produce one ID card for all members, integrate data, steer members to COEs and utilize Smart Shopper and other State programs.

1000 words.

5.3.26 Describe any relevant experience your organization has had in coordinating with an outside concierge service vendor.

1000 words.

5.4 MEMBER COMMUNICATION

5.4.1 Vendor will prepare benefit booklets/summaries, ID cards, and other plan descriptive material. Materials will be mailed directly to the home residence of the participant prior to the contract effective date.

Single, Radio group.

- 1: Agree,
- 2: Disagree

5.4.2 Confirm that, if selected, your firm will pay its pro rata share of cost of preparing and mailing open enrollment materials to plan members.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed: [500 words]

5.4.3 Identify your standard communication materials and indicate those that can be customized at no additional charge and those that require an additional charge. Indicate fee if there is an additional charge.

	Response	Amount of Fee
Member ID Cards	<i>Single, Radio group.</i> 1: Standard, 2: Custom, 3: Additional Fee	500 words. Nothing required
Claim Forms	<i>Single, Radio group.</i> 1: Standard, 2: Custom,	500 words. Nothing required

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	3: Additional Fee	
Explanation of Benefits (EOBs)	<i>Single, Radio group.</i> 1: Standard, 2: Custom, 3: Additional Fee	500 words. Nothing required
Internet Access	<i>Single, Radio group.</i> 1: Standard, 2: Custom, 3: Additional Fee	500 words. Nothing required
General Letters and Correspondence sent to Participants	<i>Single, Radio group.</i> 1: Standard, 2: Custom, 3: Additional Fee	500 words. Nothing required
Annual Benefit Statements	<i>Single, Radio group.</i> 1: Standard, 2: Custom, 3: Additional Fee	500 words. Nothing required
HIPAA Privacy Notices	<i>Single, Radio group.</i> 1: Standard, 2: Custom, 3: Additional Fee	500 words. Nothing required
HIPAA Proof of Coverage document	<i>Single, Radio group.</i> 1: Standard, 2: Custom, 3: Additional Fee	500 words. Nothing required

5.4.4 Confirm that staff will be available and participate in the State's Open Enrollment communications campaign. Describe your involvement and how you will assist members in learning about their benefit options. Note that Open Enrollment periods are generally from May 1st to June 1st each year for active employees and non-Medicare eligible retirees.

Single, Radio group.

- 1: Confirmed, Explain: [Unlimited] ,
- 2: Not confirmed, Explain: [Unlimited]

5.4.5 Confirm that your organization will conduct on-site, statewide educational sessions for the State's eligible members and dependents of eligible members beginning no later than the start of the Open Enrollment period.

Single, Radio group.

- 1: Confirmed: [500 words] ,
- 2: Not confirmed: [500 words]

5.5 ADDITIONAL MEMBER SERVICES

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5.5.1 Gaps in Care

5.5.1.1 What are your organization's categories of gaps in care and how do you quantify them?

1000 words.

5.5.1.2 Describe how your organization identifies and monitors patient gaps in care.

1000 words.

5.5.1.3 Describe how you outreach to the identified member and their physicians to close these gaps.

1000 words.

5.5.2 Concierge and Navigation Services

5.5.2.1 Describe any member advocacy, concierge services, navigation services, or programs you offer in addition to the traditional core member services center.

1000 words.

5.5.2.2 How do these additional services improve the member experience?

1000 words.

5.5.2.3 What specific outcomes have you achieved with clients that utilize the advocacy and navigation programs?

1000 words.

5.5.2.4 Do you use emerging technology such as artificial intelligence and machine learning to improve the caller experience? If yes, describe how this is used and provide any results achieved.

1000 words.

5.5.3 24-hour Nurse Line

5.5.3.1 Confirm you offer a 24-hour nurse line with staff available 24-hours a day, 365 days a year.

Single, Radio group.

1: Confirmed,

2: Not confirmed

5.5.3.2 Is your 24-hour nurse line service in-house or subcontracted?

Single, Radio group.

1: Yes,

2: No

5.5.3.3 Confirm that the 24-hour Nurse line is available in languages other than English.

Single, Pull-down list.

1: Confirmed,

2: Not confirmed

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5.5.3.4 Confirm that a member's PCP may be contacted when they engage with the 24-hour nurse provider. If a member does not have a PCP, confirm that the nurse line will follow up with patient.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

5.5.3.5 How does the nurse line integrate with other health care management components?

1000 words.

5.5.3.6 Provide utilization statistics for 2017 and 2018 for your 24-Hour Nurse Line.

	2017	2018
Total number of member calls to the 24-Hour nurse line	<i>Integer.</i>	<i>Integer.</i>
Total number of unique member calls to the 24-hour nurse line as a percent of total covered membership	<i>Integer.</i>	<i>Integer.</i>

5.6 ACCOUNT MANAGEMENT/ CLIENT SERVICES

5.6.1 Provide contact information for the Account Executive that will be assigned to this engagement.

Company Name	<i>100 words.</i>
Contact Name	<i>100 words.</i>
Contact Title	<i>100 words.</i>
Address	<i>100 words.</i>
Office Number	<i>50 words.</i>
Mobile Number	<i>50 words.</i>

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e-Mail Address	100 words.
Company URL (web address)	100 words.

5.6.2 Identify the key account management team you propose to work on this account. At a minimum, your team should include an Account Executive, Account Manager, Medical Director, Disease Management Manager, Underwriter, Member Service Manager, Implementation Coordinator, Claims Manager, and an IT Coordinator. For each team member listed, identify whether this staff member will be 100% dedicated to the State account. If the member is not 100% dedicated to State, please indicate the percentage of time the staff member will designate to the State account as well as the number of other clients with which the staff member has responsibilities.

1000 words.

5.6.3 Provide an organization chart, including names and titles, of management and key personnel that will be responsible for the management of the State account.

Single, Pull-down list.

- 1: Attached,
- 2: Not provided

5.6.4 Provide the following information regarding the account service team that would be assigned to this account.

	Name	Location	Years of Industry Experience	Years in Current Position	Relevant Qualifications	Number of Accounts Currently Assigned	Brief Description of Staff Member's Job Functions
Account Executive	50 words.	50 words.	Integer.	Integer.	500 words.	Integer.	500 words.
Account Manager	50 words.	50 words.	Integer.	Integer.	500 words.	Integer.	500 words.
Medical Director	50 words.	50 words.	Integer.	Integer.	500 words.	Integer.	500 words.
Disease Management Manager	50 words.	50 words.	Integer.	Integer.	500 words.	Integer.	500 words.

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Underwriter	50 words.	50 words.	Integer.	Integer.	500 words.	Integer.	500 words.
Member Service Manager	50 words.	50 words.	Integer.	Integer.	500 words.	Integer.	500 words.
Implementation Coordinator	50 words.	50 words.	Integer.	Integer.	500 words.	Integer.	500 words.
Claims Manager	50 words.	50 words.	Integer.	Integer.	500 words.	Integer.	500 words.
IT Coordinator	50 words.	50 words.	Integer.	Integer.	500 words.	Integer.	500 words.
Other	50 words.	50 words.	Integer.	Integer.	500 words.	Integer.	500 words.

5.6.5 Confirm the Account Executive and other account management personnel, as needed, will be available for direct outreach to members.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed: [500 words]

5.6.6 Confirm that you will respond to all inquiries from the State's staff within one (1) business day.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed: [500 words]

5.6.7 Confirm your team will attend onsite meetings upon request to present current plan and service performance, address any recent issues/challenges encountered, suggest potential savings opportunities specifically applicable to the State's plan, and discuss other pertinent topics to be identified prior to each meeting. At a minimum, the State requests that the appropriate clinical and analytical team members closely involved in the daily operations of the account and the Account Executive and Account Manager with oversight responsibility attend all meetings.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

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5.7 REFERENCES

5.7.1 Please provide references of three (3) current clients of similar size and industry for which you provide similar services. At least one of these references must be a public sector plan with at least 50,000 covered lives.

	Company Name	Contact Name	Contact Title	Telephone	Email Address	Contract Start Date	Products/Services Offered	Number of Lives Covered
Reference 1	50 words.	50 words.	50 words.	50 words.	50 words.	To the day.	50 words.	Integer.
Reference 2	50 words.	50 words.	50 words.	50 words.	50 words.	To the day.	50 words.	Integer.
Reference 3	50 words.	50 words.	50 words.	50 words.	50 words.	To the day.	50 words.	Integer.

5.7.2 Please provide references of three (3) former clients of similar size and industry for which you provided similar services and the reason for termination.

	Company Name	Contact Name	Contact Title	Telephone	Email Address	Contract Termination Date	Products/Services Offered	Number of Lives Covered	Reason for Termination
Reference 1	50 words.	50 words.	50 words.	50 words.	50 words.	To the day.	50 words.	Integer.	50 words.
Reference 2	50 words.	50 words.	50 words.	50 words.	50 words.	To the day.	50 words.	Integer.	50 words.

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Reference 3	50 words.	50 words.	50 words.	50 words.	50 words.	To the day.	50 words.	Integer.	50 words.
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5.8 ELIGIBILITY

5.8.1 Confirm that you will update eligibility data within 24 hours from receipt of data for the State Plan and the Partnership Plan.

Single, Radio group.

1: Confirmed,

2: Not confirmed, please explain: [500 words]

5.8.2 Confirm that you will provide direct same day email confirmation that the eligibility file was received, properly loaded, processed, and that this confirmation will include the date of receipt, for the State Plan and the Partnership Plan.

Single, Radio group.

1: Confirmed,

2: Not confirmed, please explain: [500 words]

5.8.3 Confirm you will post remaining data, not identified as errant, within 24 hours, for the State Plan and the Partnership Plan.

Single, Pull-down list.

1: Confirmed,

2: Not Confirmed

5.8.4 Confirm you will provide the State with online access to their enrollment information, for the State Plan and the Partnership Plan, in real time.

Single, Pull-down list.

1: Confirmed,

2: Not Confirmed

5.8.5 Can the State staff make eligibility changes online?

Single, Radio group.

1: Yes, please explain: [Unlimited] ,

2: No

5.9 CLAIMS PROCESSING

5.9.1 With regard to the claim offices that will be used, provide the following:

Position	Number of Staff	Average Years of Total Claims Administration Experience	Average Years of Claims Administration Experience with Your Firm	Annual Turnover (%)	Work Remotely or from Home (%)

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Claims Processors	<i>Integer.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Percent.</i>	<i>Percent.</i>
Claims Supervisors	<i>Integer.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Percent.</i>	<i>Percent.</i>
Claims Managers	<i>Integer.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Percent.</i>	<i>Percent.</i>
Auditors	<i>Integer.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Percent.</i>	<i>Percent.</i>
Quality Control Managers	<i>Integer.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Percent.</i>	<i>Percent.</i>
Clinical Review Staff	<i>Integer.</i>	<i>Decimal.</i>	<i>Decimal.</i>	<i>Percent.</i>	<i>Percent.</i>

5.9.2 What safeguards are in place to monitor quality (including retrospective claims reviews) and HIPAA compliance for staff that work from home?

200 words.

5.9.3 How are claims, customer service, utilization review and case management systems linked?

Single, Radio group.

- 1: Same system,
- 2: Integrated, but different systems,
- 3: Different systems, but accessible to all,
- 4: Not linked,
- 5: Some linked,
- 6: Other, please specify: [500 words]

5.9.4 Does your claims system have the capability to automatically match claims with utilization management information both in- and out-of-network?

Single, Pull-down list.

- 1: Yes,
- 2: No

5.9.5 Please complete the following table regarding auto-adjudicated claims:

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What percentage of total claims are auto-adjudicated for your national Book of Business?	<i>Percent.</i>
What percentage of total claims are auto-adjudicated for your State of Connecticut Book of Business?	<i>Percent.</i>

5.9.6 Does your claims system have the capability to process network, non-network, out of State or regional claims on the same system?

Single, Pull-down list.

- 1: Yes,
- 2: No

5.9.7 Describe your process to review claims for billing irregularities by provider (such as regular overcharging, unbundling of procedures, upcoding or billing for inappropriate care for stated diagnosis, etc.)?

500 words.

5.9.8 How are claims selected for internal audit? What triggers do you utilize?

Multi, Checkboxes.

- 1: Random by system,
- 2: Set percent per day,
- 3: Set number per approver per day/week,
- 4: Diagnosis,
- 5: Dollar amount,
- 6: Other, please specify: [500 words]

5.9.9 On average, what percentage of all claims are audited by an internal audit group?

Percent.

5.9.10 What are your procedures for recovery of overpayments or duplicate payments? How do those procedures differ for in-network vs. out-of-network providers?

1000 words.

5.9.11 What are your procedures for recovery of overpayments on claims that require subrogation?

1000 words.

5.9.12 How do you screen for and identify claims that could be the responsibility of a third- party? Please explain your process in detail including details on any subcontractors or vendors your organization uses to research and/or recoup.

1000 words.

5.9.13 Confirm you agree to return 100% of all recovered monies from overpayments, duplicate payments, and overpayments on third-party liability or subrogation claims, or other processing errors to the State, without a processing fee?

Single, Pull-down list.

- 1: Confirmed,
- 2: Not Confirmed

5.9.14 Describe your process for claim coding audits. How often and what percent of claims are audited for proper claim coding?

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1000 words.

5.9.15 Do you agree to hold the State harmless for any liability arising from your firm's payment processing errors that result in overpayment or duplication of payments to providers?

1000 words.

5.9.16 Using most recent year-end data, complete the table below for the claim office that will have payment responsibility for this account:

	Target	Actual 2018 year end results
Total annual claim volume per year (in total number of claims)	500 words.	500 words.
Average claims processed per processor per day	500 words.	500 words.
Claims turnaround time (percent of clean claim transactions processed within 14 calendar days following receipt of claim)	500 words.	500 words.
Average number of business days to process a clean claim from date received to date check/EOB issued	Decimal.	Decimal.
Financial accuracy (percentage of total claim dollars paid without error, relative to total claim dollars paid)	500 words.	500 words.
Processing accuracy (percentage of claims processed without error, relative to the total number of claims processed)	500 words.	500 words.
What percent of all non-clean claims submitted are processed (from date received to date check/EOB issued) within 10 business days?	Percent.	Percent.
What percent of all non-clean claims submitted are processed (from date received to date check/EOB issued) within 30 business days?	Percent.	Percent.

5.9.17 Are your eligibility and claim systems compliant with current HIPAA regulations?

Single, Pull-down list.

- 1: Yes,
- 2: No

5.9.18 Confirm that you will review and process all waivers related to the ER copay and Site of Service program. The vendor will notify members of the determination and provide monthly reporting.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not Confirmed.

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5.10 COORDINATION OF BENEFITS (COB)

5.10.1 Explain how your system:

- a. Identifies existence of other insurance (e.g., from your book of business, another employer, workers compensation or motor vehicle insurance);
- b. Questions/tracks COB;
- c. Handles COB conflicts;
- d. Communicates with members and providers;
- e. Interfaces with other group carriers regarding COB;
- f. Monitors Medicare eligibility and enrollment.

1000 words.

5.10.2 When you are the secondary payer in a COB situation, do you use your usual, customary, and reasonable (UCR) profiles, reduced network fees, or those of the primary carrier in determining your level of reimbursement?

1000 words.

5.10.3 How is the State held harmless for erroneous payments made by you during the COB process?

1000 words.

5.10.4 Please complete the following table:

Average COB savings as a percent of total plan	<i>Percent.</i>
Will you guarantee COB savings?	<i>Single, Pull-down list.</i> 1: Yes, 2: No

5.10.5 Confirm you will provide a monthly subrogation report specific to the State. Provide a sample of the monthly reporting that will be provided to the State.

Single, Radio group.

- 1: Confirmed with monthly subrogation report attached , explain: [500 words] ,
- 2: Not Confirmed

5.10.6 Confirm that when spouses are both employees of the State and enrolled in the plan there will not be a coordination of benefits with the plan.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed, explain: [500 words]

5.11 COBRA

5.11.1 COBRA services must be included. ASO Administrative Fees should include pricing for COBRA services. Confirm your agreement with this provision.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed, explain: [500 words]

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5.11.2 Can COBRA eligibility be provided through an on-line data entry system? Describe your system and the process for submitting COBRA eligibility.

1000 words.

5.11.3 How will you communicate and house enrollment eligibility for COBRA participants? Are you equipped to maintain member and dependent enrollment data for all plans?

1000 words.

5.11.4 Confirm you will also provide COBRA premium billing and collection for prescription and dental benefits.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, explain: [500 words]

5.11.5 Describe how you will track those that elect COBRA, when they are no longer eligible, when they are delinquent in premium payments, when they must be terminated and how you will communicate this information to the State, members, and/or additional vendors.

1000 words.

5.11.6 A small number of retirees (roughly 500) are considered non-pension retirees. These individuals do not collect a monthly pension check from the State, or receive a monthly pension check that is not large enough to cover their monthly premium shares. Confirm that you will be able to bill and collect premiums these individuals on behalf of the State.

Single, Radio group.

1: Confirmed,

2: Not Confirmed, explain: [500 words]

5.12 NETWORK MANAGEMENT

5.12.1 What is your firm's current book-of-business in-network utilization percentage?

Percent.

5.12.2 Please provide your network provider turnover rate.

	Current Year	Prior Year
Provider Turnover Rate	<i>500 words.</i>	<i>500 words.</i>

5.12.3 Describe separately the out-of-service area, regional, out-of-state, and out-of-country coverage for your PPO products for routine, urgent and emergency care.

500 words.

5.12.4 What criteria are used to identify the situations where there is no access to in-network providers?

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Single, Radio group.

- 1: Mileage,
- 2: Travel Time,
- 3: Other (explain): [500 words]

5.12.5 Are there any services or specialists that are not available in your physician networks in the service areas where there are plan participants? If yes, please identify them and explain what provisions are made for patients requiring these services.

1000 words.

5.12.6 If the Vendor or the State identifies a network gap or deficiency, how do you address the need for additional providers?

1000 words.

5.12.7 Confirm that you will maintain an accurate online directory of in-network providers to which the State's members may refer and that this directory is updated at least weekly.

Single, Radio group.

- 1: Confirmed, please indicate how often your directory is updated: [1000 words] ,
- 2: Not Confirmed

5.12.8 Confirm that you are able to provide the following minimum data elements for the provider inquiries:

	Response
Provider or Facility Name	<i>Single, Radio group.</i> 1: Confirmed, 2: Not confirmed
Provider Address and telephone number	<i>Single, Radio group.</i> 1: Confirmed, 2: Not confirmed
Web address	<i>Single, Radio group.</i> 1: Confirmed, 2: Not confirmed
Medical Group	<i>Single, Radio group.</i> 1: Confirmed, 2: Not confirmed
Practicing Specialty(ies)	<i>Single, Radio group.</i> 1: Confirmed, 2: Not confirmed
Specialist Board Certified	<i>Single, Radio group.</i> 1: Confirmed, 2: Not confirmed
Providers that are not accepting new patients	<i>Single, Radio group.</i>

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	1: Confirmed, 2: Not confirmed
Age/gender limitations	<i>Single, Radio group.</i> 1: Confirmed, 2: Not confirmed

5.12.9 Please provide a general description on how you establish your organization's networks and the corresponding financial arrangements.

500 words.

5.12.10 Do you wholly own, partially own or lease your network?

Single, Radio group.

1: Wholly own,

2: Partially own,

3: Lease,

4: Other, please specify: [500 words]

5.12.11 If you lease (or have a reciprocal agreement with) any portion of your network, describe how you will ensure continuity of care for the State's members receiving care from a provider that is part of the leased network.

1000 words.

5.12.12 Describe the claims payment process for out of network claims processed by the leased or reciprocal network. How are the out of network providers identified and communicated to the State?

1000 words.

5.12.13 Describe the medical management process for out of network claims processed by the leased or reciprocal network. How are the out of network providers identified and communicated to the State?

1000 words.

5.12.14 Do you use a secondary (wrap) network for providers not in your primary provider network? If so, please describe the network used.

1000 words.

5.12.15 How much notice is a provider contractually required to give if they elect to terminate a contract with your network(s)?

1000 words.

5.12.16 Explain how the State will be informed of major contract disputes or potential network disruption to its members.

1000 words.

5.12.17 How do you monitor non-network utilization and what steps do you take to contract with these providers?

1000 words.

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5.12.18 Confirm you will require participating hospitals to bill services rendered at free-standing emergency rooms separately from emergency room services performed at the hospital's main facility.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.12.19 Do your contracts require hospitals to bill urgent care rates for urgent care visits even if they present in an emergency room for treatment? For example, if a patient schedules a visit through the emergency room in advance, does your contract require urgent care billing for these services?

Single, Radio group.

- 1: Yes,
- 2: No

5.12.20 If certain hospital based physicians (radiology, anesthesiology, ER, etc.) or services (ambulance, etc.) are not represented in your network of providers, can you administer these claims at the in-network benefit level when network hospitals are used?

Single, Pull-down list.

- 1: Yes,
- 2: No

5.12.21 The State has a site of service network in which lower cost providers are preferred with a zero dollar copay for lab and imaging services; non-preferred high-cost in-network providers have a 20% co-insurance. Please provide the criteria you would propose to identify preferred and non-preferred in-network lab and imaging providers. How often would the preferred and non-preferred tiers be reviewed and adjustments made? How would you incorporate image quality standards into the tiering criteria or prior authorization process to avoid unnecessary duplicate imaging services?

1000 words.

5.12.22 Are any of your health care management programs accredited? If so, list which programs (e.g., utilization review, case management), by what organization (NCQA, URAC) and the current accreditation status?

1000 words.

5.12.23 Check off those elements that are included in the provider selection process and provide the estimated percentage of network providers that satisfy the following selection criteria elements:

	In Selection Process	% of Providers
Require unrestricted state licensure	<i>Yes/No.</i>	<i>Percent.</i>
Review malpractice coverage and history	<i>Yes/No.</i>	<i>Percent.</i>
Require full disclosure of current litigation	<i>Yes/No.</i>	<i>Percent.</i>

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Require current DEA registration	<i>Yes/No.</i>	<i>Percent.</i>
Review adherence to state and community practice standards	<i>Yes/No.</i>	<i>Percent.</i>
Onsite review of office location	<i>Yes/No.</i>	<i>Percent.</i>
Review hours of operation and capacity	<i>Yes/No.</i>	<i>Percent.</i>
Board eligibility	<i>Yes/No.</i>	<i>Percent.</i>
Review practice patterns and utilization results	<i>Yes/No.</i>	<i>Percent.</i>

5.12.24 How do you assess physician performance? Include in your response the programs in place, the quality metrics used, and how you monitor and measure performance results.

1000 words.

5.12.25 What performance information will be shared with the State? What performance information is shared with providers? Please provide the exact algorithms used to perform physician assessments.

1000 words.

5.12.26 What percentage of physicians, non-physician providers and facilities are credentialed prior to contracting (including physicians with leased health plans or with a reciprocal arrangement)?

1000 words.

5.12.27 What classes or types of providers are not considered for credentialing? For example, are Board Certified Behavior Analysts who treat autism spectrum disorders credentialed and included in your network?

1000 words.

5.12.28 Describe your quality improvement initiatives.

1000 words.

5.12.29 How do you detect underutilization/overutilization by providers, specifically those in shared savings or risk bearing contracts? How are such situations addressed?

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1000 words.

5.12.30 Confirm your willingness to provide, to the State, transparency of pricing and other financial information, including compensation and prices, allowed and billed claim costs, the terms of any risk sharing arrangements, incentives, and pay-for-performance reimbursement, future contractual rate increases by hospital, fee schedules as a percent of Medicare for in-patient and outpatient services by hospital.

Single, Radio group.

1: Confirmed,

2: Not Confirmed (please explain):

5.12.31 How closely do you monitor and track the performance of the DME network? Please include specifics regarding frequency of monitoring as well as measurements.

1000 words.

5.12.32 How do you reimburse the cost of DME given to the member by the provider at the time of service or upon discharge? How is reimbursement calculated?

1000 words.

5.12.33 Please describe any ongoing or planned efforts to limit or lower DME costs and rationalize pricing both in and out of network.

1000 words.

5.12.34 How many provider advocates do you have working in the State of Connecticut? Please list those employees physically working in Connecticut and those working telephonically in Connecticut.

1000 words.

5.12.35 Does your organization provide satisfaction surveys to providers? If so, describe the survey and uses of results.

1000 words.

5.12.36 What are your capabilities to provide actual physician outcome quality data to members so that they can make wiser choices regarding where they seek care and in turn realize better and lower cost outcomes for the Plan?

1000 words.

5.12.37 Describe your Transplant network.

1000 words.

5.13 PROVIDER REIMBURSEMENT

5.13.1 What percentage of physician contracts contain performance metrics related to (1) preventive care and screening activities and (2) clinical outcomes both nationally and in Connecticut?

1000 words.

5.13.2 What are your goals for the percentage of dollars at risk based on these clinical quality metrics?

1000 words.

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5.13.3 What percentage of physician contracts contain performance metrics for (1) generic or low-cost drug prescribing and (2) in-network referral for lab, imaging, and other medical services?

1000 words.

5.13.4 What are your goals for the percentage of dollars at risk based on these cost-containment metrics?

1000 words.

5.13.5 What percentage of physician contracts contain performance metrics for improved clinical metrics (i.e. lower A1C, cholesterol, blood pressure, improved physical activity and nutrition, etc.?)

1000 words.

5.13.6 What are your goals for the percentage of dollars at risk based on these clinical quality metrics?

1000 words.

5.13.7 Describe any other value-based contracting practices you have in place both nationally and in Connecticut.

1000 words.

5.13.8 Describe your risk based contracting philosophy and strategy.

1000 words.

5.13.9 Do your risk-based contracts include prescription drugs administered through the medical benefit?

1000 words.

5.13.10 Do your contracts include retail prescription drug costs in at-risk total cost of care arrangements? If not, please indicate your willingness to expand total cost of care contracts to incorporate retail prescription drug costs for the state employee plan.

1000 words.

5.13.11 Can the State's members be carved out of ACO contracts with carriers to develop separate custom risk-based contracting?

1000 words.

5.13.12 Can you administer a State specific core set of quality metrics in addition to other metrics you may utilize?

Single, Radio group.

1: Confirmed, (please explain);

2: Not Confirmed

5.13.13 What is the percentage of risk-based contracts your organization has in place nationally and in Connecticut specifically?

Percentage of risk-based contracts your organization has in place nationally	<i>Percent.</i>
Percentage of risk-based contracts your organization has in place in Connecticut	<i>Percent.</i>

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5.13.14 Describe your efforts to inform providers of their performance metrics and your strategies to help providers improve quality and clinical outcomes. If risk scores are part of process, please elaborate.

1000 words.

5.13.15 What maximum annual increase to network provider fees will you guarantee in year 2 of this contract? For example, maximum increase may be defined as the weighted average increase in physician charges based on a uniform list of top 100 CPT codes.

1000 words.

5.13.16 What is the maximum annual increase to network facility fees you will guarantee in year 2 of this contract? Please define the method for defining facility fee increases.

1000 words.

5.13.17 How often do you monitor and report increases in physician payments for both in- network and out-of-network providers? Do you have the ability to monitor and report significant changes or “outliers” to the State in real time?

1000 words.

5.13.18 Do you use billing and coding criteria for emergency room visits? If yes, please provide a copy of the criteria and a list of Connecticut hospitals contracted to apply the criteria. Please provide results for any hospital audits performed to ensure compliance.

1000 words.

5.13.19 Indicate non-network provider fees, such as UCR percentile or maximum allowable charge, used for non-network reimbursement.

1000 words.

5.13.20 Indicate the source of non-network provider fees (First Health, Medicare, ADP, Other).

1000 words.

5.13.21 Please describe any surcharges, adjustments, mark-ups or other fees that would be included in claims or applied in connection with using a network provider located outside your geographic area.

1000 words.

5.13.22 Do your provider contracts with network hospitals require that members be informed of the possibility of balance billing by non-network providers operating within the facility (for example, anesthesiology, radiology or emergency department services) in advance of admission to or treatment within such facility?

1000 words.

5.13.23 Indicate what percentage of facility reimbursement is through the following types of payments for the network being proposed:

	Inpatient Hospital (%)	Outpatient Hospital (%)	Other Outpatient Facilities (%)
DRG	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>

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APC or other OP per case	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Discount off Charges	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Bundled Payment	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Per diem rate (by bed type)	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Per diem rate (global)	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Other (specify in additional rows)	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Total	100%	100%	100%

5.13.24 Describe how network hospitals are reimbursed. If reimbursement varies by geographic location, identify reimbursement arrangements by area for those relevant to the State's membership. Please be specific for each Connecticut hospital.

Predominant Area: <i>State of Connecticut</i>	Full Service Hospital Acute Care Inpatient Facility	Full Service Hospital Acute Care Outpatient Facility	Ambulatory Surgical Facility	Behavioral Health Facilities	Other
Number of Hospitals/ Facilities	<i>500 words.</i>	<i>500 words.</i>	<i>500 words.</i>	<i>500 words.</i>	<i>500 words.</i>
Hospital Payment Method Per diem, per admission, other describe:	<i>500 words.</i>	<i>500 words.</i>	<i>500 words.</i>	<i>500 words.</i>	<i>500 words.</i>
Ratio of network hospital charges to Medicare payment	<i>500 words.</i>	<i>500 words.</i>	<i>500 words.</i>	<i>500 words.</i>	<i>500 words.</i>
Minimum network hospital discount guarantee (as a ratio of Medicare payments)	<i>500 words.</i>	<i>500 words.</i>	<i>500 words.</i>	<i>500 words.</i>	<i>500 words.</i>

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What overall maximum increase to network hospital room and board rates will you guarantee in the second year of this contract?	500 words.	500 words.	500 words.	500 words.	500 words.
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5.13.25 What do your in-network rates average relative to Medicare for the following.

Category	Average Contracted Payment Relative to Medicare
Hospital Inpatient	Percent.
Hospital Outpatient	Percent.
Physician	Percent.
Overall	Percent.

5.13.26 Please provide the Contracted Payment Relative to Medicare at your top 5 hospitals in Conn. for Inpatient services for the following:

Category	Average Contracted Payment Relative to Medicare
Orthopedics	
Orthopedics – Hospital 1	Percent.
Orthopedics – Hospital 2	Percent.
Orthopedics – Hospital 3	Percent.
Orthopedics – Hospital 4	Percent.
Orthopedics – Hospital 5	Percent.
Childbirth	

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Childbirth – Hospital 1	<i>Percent.</i>
Childbirth – Hospital 2	<i>Percent.</i>
Childbirth – Hospital 3	<i>Percent.</i>
Childbirth – Hospital 4	<i>Percent.</i>
Childbirth – Hospital 5	<i>Percent.</i>
Substance Use Disorder	
Substance Use Disorder – Hospital 1	<i>Percent.</i>
Substance Use Disorder – Hospital 2	<i>Percent.</i>
Substance Use Disorder – Hospital 3	<i>Percent.</i>
Substance Use Disorder – Hospital 4	<i>Percent.</i>
Substance Use Disorder – Hospital 5	<i>Percent.</i>
Mental Health	
Mental Health – Hospital 1	<i>Percent.</i>
Mental Health – Hospital 2	<i>Percent.</i>
Mental Health – Hospital 3	<i>Percent.</i>
Mental Health – Hospital 4	<i>Percent.</i>

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Mental Health – Hospital 5	<i>Percent.</i>
Circulatory System Conditions	
Circulatory System Conditions – Hospital 1	<i>Percent.</i>
Circulatory System Conditions – Hospital 2	<i>Percent.</i>
Circulatory System Conditions – Hospital 3	<i>Percent.</i>
Circulatory System Conditions – Hospital 4	<i>Percent.</i>
Circulatory System Conditions – Hospital 5	<i>Percent.</i>
Respiratory System Conditions	
Respiratory System Conditions – Hospital 1	<i>Percent.</i>
Respiratory System Conditions – Hospital 2	<i>Percent.</i>
Respiratory System Conditions – Hospital 3	<i>Percent.</i>
Respiratory System Conditions – Hospital 4	<i>Percent.</i>
Respiratory System Conditions – Hospital 5	<i>Percent.</i>
Total Inpatient	
Total Inpatient – Hospital 1	<i>Percent.</i>
Total Inpatient – Hospital 2	<i>Percent.</i>

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Total Inpatient – Hospital 3	<i>Percent.</i>
Total Inpatient – Hospital 4	<i>Percent.</i>
Total Inpatient – Hospital 5	<i>Percent.</i>

5.13.27 Please provide the Contracted Payment Relative to Medicare at your top 5 hospitals in Connecticut for Outpatient services for the following:

Category	Average Contracted Payment Relative to Medicare
Emergency Dept. Visits	
Emergency Dept. Visits – Hospital 1	<i>Percent.</i>
Emergency Dept. Visits – Hospital 2	<i>Percent.</i>
Emergency Dept. Visits – Hospital 3	<i>Percent.</i>
Emergency Dept. Visits – Hospital 4	<i>Percent.</i>
Emergency Dept. Visits – Hospital 5	<i>Percent.</i>
Percutaneous Coronary Intervention	
Percutaneous Coronary Intervention – Hospital 1	<i>Percent.</i>
Percutaneous Coronary Intervention – Hospital 2	<i>Percent.</i>
Percutaneous Coronary Intervention – Hospital 3	<i>Percent.</i>
Percutaneous Coronary Intervention – Hospital 4	<i>Percent.</i>

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Percutaneous Coronary Intervention – Hospital 5	<i>Percent.</i>
Endoscopy	
Endoscopy – Hospital 1	<i>Percent.</i>
Endoscopy – Hospital 2	<i>Percent.</i>
Endoscopy – Hospital 3	<i>Percent.</i>
Endoscopy – Hospital 4	<i>Percent.</i>
Endoscopy – Hospital 5	<i>Percent.</i>
Laparoscopic Surgery	
Laparoscopic Surgery – Hospital 1	<i>Percent.</i>
Laparoscopic Surgery – Hospital 2	<i>Percent.</i>
Laparoscopic Surgery – Hospital 3	<i>Percent.</i>
Laparoscopic Surgery – Hospital 4	<i>Percent.</i>
Laparoscopic Surgery – Hospital 5	<i>Percent.</i>
Advanced Imaging	
Advanced Imaging – Hospital 1	<i>Percent.</i>
Advanced Imaging – Hospital 2	<i>Percent.</i>

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Advanced Imaging – Hospital 3	<i>Percent.</i>
Advanced Imaging – Hospital 4	<i>Percent.</i>
Advanced Imaging – Hospital 5	<i>Percent.</i>
Total Outpatient	
Total Outpatient – Hospital 1	<i>Percent.</i>
Total Outpatient – Hospital 2	<i>Percent.</i>
Total Outpatient – Hospital 3	<i>Percent.</i>
Total Outpatient – Hospital 4	<i>Percent.</i>
Total Outpatient – Hospital 5	<i>Percent.</i>

5.13.28 Please provide the scheduled rate increases and effective dates of such rate increases for each hospital as required by existing provider contracts. Please break-out by in-patient and out-patient by hospital.
1000 words.

5.13.29 How are network outpatient facilities such as surgicenters, imaging centers and laboratories reimbursed (on a discounted fee arrangement, percent of Medicare APCs, prepaid capitated arrangement)? If a scheduled fee arrangement is the basis for reimbursement, describe how the scheduled fees are derived.
1000 words.

5.13.30 The State is interested in understanding the movement in your discounts over time. Illustrate the change in your provider discounts, as a percentage increase or decrease, for each of the past five (5) years. Please provide them separately for hospital inpatient, hospital outpatient, and professional services.
1000 words.

5.13.31 Describe any other contractual relationships you maintain with any other providers such as pharmacies, physical therapists, orthotics suppliers, prosthetic suppliers, vision care and home health care providers.
1000 words.

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5.13.32 Explain any financial incentives (bonuses) or disincentives (withholds) in network provider contracts or for network hospitals that are tied to utilization goals, specialty referrals, member survey results, readmission rates, quality of care outcomes or other performance results.

1000 words.

5.13.33 Please provide the contract expiration date and anticipated renegotiation date for each hospital in the State of Connecticut. If you anticipate renegotiating provider contracts in the next 12, 24 or 36 months please describe the planned changes and anticipated impact on your book-of-business premium rates.

1000 words.

5.13.34 Please provide a sample contract that you use for network hospitals.

Single, Radio group.

1: Attached,

2: Not Attached

5.13.35 Please provide a copy of your current contracts with all hospitals in the State of Connecticut.

Single, Radio group.

1: Attached,

2: Not Attached

5.14 TIERED NETWORKS AND HIGH PERFORMANCE NETWORKS

5.14.1 Describe your current tiered-network and high quality/high performance network capabilities.

1000 words.

5.14.2 What impact do you expect these will have on trend? Please provide results for each year of the contract.

1000 words.

5.14.3 Provide a listing of the markets where these networks are currently available, including plans for future expansion.

1000 words.

5.14.4 What types of medical providers/facilities are in these networks?

1000 words.

5.14.5 Describe your programs to evaluate physicians and facilities for your high quality/performance network, specifically addressing the following:

- Criteria (e.g., quality, cost, efficiency)
- How is quality information conveyed to plan enrollees?
- What are your sources of quality and performance information on physicians and facilities?

1000 words.

5.14.6 Do you currently rank providers based on quality and/or cost? If "yes" how do you determine the specific quality ranking of each provider and facility? How often is each provider's quality ranking revisited?

1000 words.

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5.14.7 Please identify tiered or high performance network providers by notations in provider directory submitted with your proposal or on a separate listing.

1000 words.

5.14.8 Confirm that information regarding Connecticut providers and their designated tier category is made available to the members so they can make informed decisions about the cost and quality of the provider they choose.

Single, Radio group.

1: Confirmed,

2: Not confirmed

5.14.9 Is your system capable of administering plan design differentials when a tiered network is in place?

Single, Radio group.

1: Yes,

2: No

5.14.10 Do you have a minimum benefit differential requirement between Tier 1 and Tier 2? If so, what is the minimum differential?

1000 words.

5.14.11 When offering a tiered network arrangement, do you require that members select a PCP? If so, must the PCP be designated as a Tier 1 provider?

1000 words.

5.14.12 Is your Tiered network associated with an ACO arrangement, where Tier 1 physicians are ACO network providers?

1000 words.

5.14.13 How do you engage and drive consumers to use high quality, high performance medical providers in your high performance network?

1000 words.

5.14.14 What type of reporting will you provide to the State regarding your high quality, high performance medical providers?

1000 words.

5.14.15 The Comptroller's Office is in the process of developing a custom COE network for the State employee plan; confirm your willingness to incorporate the State's COE network, including leveraging the State's improved negotiated rates, into the State's program?

Single, Radio group.

1: Yes,

2: No, please explain: [500 words]

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5.15 ACCOUNTABLE CARE ORGANIZATIONS (ACO) AND PATIENT CENTERED MEDICAL HOMES (PCMH)

5.15.1 List all shared savings programs currently under contract. Also, provide a list of all provider groups that you anticipate putting under contract in the next 24 months, along with the timing for each. For each program, list the associated providers including their specialty and National Provider Identifier and provide a copy of the financial terms for each separate contract.

1000 words.

5.15.2 What are your strategies for evolving payment arrangements such as bundled payments, provider organizations (ACO, PCMH, etc.), and financial risk sharing? How will this benefit the State? Comment on specific payment initiatives, provider incentives, and quality and efficiency measures. Describe how you would collaborate with the State in these efforts.

Unlimited.

5.15.3 Confirm that pharmacy data will be used in determining total cost of care.

Single, Radio group.

1: Confirmed,

2: Not confirmed, explain: [500 words]

5.15.4 What types of measures are used to determine the performance-based payments?

Multi, Checkboxes.

1: Measurement of achievement relative to a target or peers for NQF-endorsed process measures,

2: Measurement of improvement over time for NQF-endorsed process measures,

3: Measurement of practice efficiency relative to a target or peers,

4: Measurement of the application of specific ACO practices,

5: Measurement of patient satisfaction,

6: Other (specify): [500 words]

5.15.5 What is the expected value of the provider payments?

Single, Pull-down list.

1: 0-5% of primary care practice annual payment,

2: 6-10% of primary care practice annual payment,

3: 11-15% of primary care practice annual payment,

4: 16-20% of primary care practice annual payment,

5: 21-25% of primary care practice annual payment,

6: >25% of primary care practice annual payment

5.15.6 What amount of value based provider payments are paid up-front as a PMPM payment and what is the percentage breakout of shared savings with the provider groups? Do any of your value payment models include downside risk?

1000 words.

5.15.7 Are there any defined expectations as to how the added payments paid to practices should be used?

Multi, Checkboxes.

1: None,

2: Funding employment of, or contracting with, clinical case managers within the practice,

3: Providing group visits,

4: Providing group education on self-management,

5: Other (specify): [500 words]

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5.15.8 How is the ACO program promoted to members?

Multi, Checkboxes.

- 1: General education materials to members,
- 2: Enrollment meetings coordinated with employees of the State,
- 3: Performance reports comparing ACO practices with non-ACO practices,
- 4: Designation in the physician directory of ACO status,
- 5: Linked messages with web-based tools to support decision-making,
- 6: Messages in EOB if member not using ACO practice,
- 7: Steerage at times of interaction with telephonic or in-person interaction with wellness or disease management programs,
- 8: Steerage at times of telephonic interaction with nurse line or telephonic treatment support,
- 9: Financial incentives unavailable through other plan options

5.15.9 Do any promotional or steerage efforts account for differences in performance across ACO groups?

Unlimited.

5.15.10 What percentage of your network providers in Connecticut are currently contracted via a risk-share formula? Please provide the percentage separately for inpatient facilities, outpatient facilities and physicians (PCP vs. Specialists separately). The percentage should represent the number of unique providers divided by the total number of unique network providers for each provider type. No providers should be counted more than once, and you must list the numerator and the denominator used to calculate the percentage inserted in each box.

Provider Type	Accountable Care Organization	Capitations or Shared Savings Contract or Bundled Payment Contract
Inpatient	50 words.	50 words.
Outpatient	50 words.	50 words.
Physician (PCP)	50 words.	50 words.
Physician (Specialist)	50 words.	50 words.

5.15.11 How is your provider risk-share target developed? Please provide a working example.

1000 words.

5.15.12 Provide the amount a provider can gain under the risk-share arrangement. This amount should be stated as a percentage of claims.

1000 words.

5.15.13 If your organization is paying providers for initiatives, who is responsible for paying them, you or your customers? Are these payments included in your administration fees or are they included in claims?

1000 words.

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5.15.14 Are you moving towards transparency of all provider fees? If yes, please elaborate.

1000 words.

5.15.15 Provide current actual results regarding the success and impact of these contracting strategies in Connecticut.

1000 words.

5.15.16 How are you going to be measuring repeat imaging and duplicative services?

1000 words.

5.15.17 What impact do you expect the alternative contracting strategies will have on trend in 2020?

1000 words.

5.15.18 What percentage of your Connecticut provider network is at full risk now, and what is the projected percentage for 2020?

1000 words.

5.15.19 The State is working with the State Innovation Model team to develop a primary care reimbursement model that optimizes returns on investments in primary care. Please indicate your willingness to work with the State to adjust PCP reimbursements as may be necessary to more efficiently distribute total plan spend, and ensure primary care has the resources required to make a significant impact on patient health outcomes and long-term total health care spend for engaged patients.

1000 words.

5.16 FRAUD, WASTE AND ABUSE

5.16.1 Describe your existing programs for detecting fraud, waste and abuse in connection with self-insured medical benefit plans. Are any of these programs specific to Durable Medical Equipment?

1000 words.

5.16.2 How do you monitor fraud, waste and abuse relative to out-of-network claims?

1000 words.

5.16.3 How do you measure success for your organization's fraud, waste and abuse prevention programs?

1000 words.

5.16.4 Confirm that, if selected, all notices sent to providers regarding required policies and procedures will be made available to the Healthcare Policy & Benefit Division of the Office of the State Comptroller/or the Connecticut Attorney General in connection with plan administration, referrals and/or investigations carried out pursuant to Public Act 14-217.

Single, Radio group.

1: Confirmed,

2: Not confirmed, explain: [500 words]

5.16.5 Confirm that, if selected, you are required to provide notice and consult with the Office of the State Comptroller and may be required to provide notice and consult with the Connecticut Attorney General upon

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the Comptroller's request prior to suspending payments to a provider or recovering any funds in a matter in which fraud, waste or abuse are suspected. Should the Comptroller require consultation with the Connecticut Attorney General you will adhere to the Connecticut Attorney General's reasonable requests to assure maximum opportunity to properly investigate the matter pursuant to Public Act 14-217.

Single, Radio group.

1: Confirmed,

2: Not confirmed, explain: [500 words]

5.17 MEDICAL MANAGEMENT

5.17.1 Describe your Utilization Management programs including your pre-service review process (i.e., precertification, prior authorization).

1000 words.

5.17.2 Describe your methods for internally monitoring and evaluating the performance of utilization management activities.

1000 words.

5.17.3 Describe your approach to large case management and complex care, including any specialty programs that are included in your proposal.

1000 words.

5.17.4 Describe the system access case managers have to medical and behavioral health records and imaged documents when handling telephonic and online inquiries.

1000 words.

5.17.5 Describe your procedures to successfully contact members selected for case management. What are all the methods in which you attempt to reach a member? How many attempts are made? What services or efforts are used to obtain updated contact information?

1000 words.

5.17.6 Please explain how you will handle transition of care whether to other facilities or to a patient's home.

Hospitalized members	<i>500 words.</i>
Members in treatment	<i>500 words.</i>
Maternity members	<i>500 words.</i>

5.17.7 How many hospital based case managers assisting with transition of care and discharge planning do you have in Connecticut? Describe the typical procedures of these case managers in terms of transition of care.

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1000 words.

5.17.8 Will your firm provide case management for out-of-network cases? For what percentage of your clients do you routinely provide case management for out-of-network cases?

1000 words.

5.17.9 Describe how you calculate case management savings. Include details on any classification schemes (e.g., hard and soft savings)?

1000 words.

5.17.10 Provide a description of the standard case management reports provided. Indicate the frequency, level of reporting, and define the data included. Provide a copy of the report template.

1000 words.

5.17.11 Describe your programs related to chronic condition management and how they will impact members with asthma, COPD, coronary artery disease, diabetes, heart failure, high blood pressure, and obesity).

1000 words.

5.17.12 Provide outcomes you have experienced with your chronic condition management programs.

1000 words.

5.17.13 Describe monitoring activities to identify gaps in care related to chronic condition management and opportunities for improvement.

1000 words.

5.17.14 Explain any financial or other incentives established for providers to comply with utilization management protocols, treatment standards or other aspects related to health care management an chronic condition management.

1000 words.

5.17.15 Do you offer obesity screening programs or nutrition-related programs? If so,

a. What types of programs do you offer?

b. How have members responded to these programs?

c. What are the results of these programs (e.g. successful long-term weight loss, reduced claim costs, etc.)?

Single, Radio group.

1: Yes, explain: [1000 words] ,

2: No

5.17.16 Do you have a network of Registered Dietitians in Connecticut? How are Registered Dietitian visits covered (i.e. must be billed as part of physician visit, must have physician referral, etc.)?

1000 words.

5.17.17 Will you accept claims data from the State's dental carrier, PBM, COE networks, and lab data from providers for health care management purposes? If yes, explain the process for this and how the information will be used. Is there an additional cost for this service?

1000 words.

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5.18 BEHAVIORAL HEALTH

5.18.1 Provide a brief overview of your program and address how your behavioral health interventions are integrated with your medical interventions. Do you have a clinically integrated delivery system that coordinates behavioral health services with medical services to improve the quality of care?

1000 words.

5.18.2 Describe the process for plan participants to access behavioral health services in a primary care setting, during chronic condition case management, during an acute inpatient episode, and during post-discharge follow up.

1000 words.

5.18.3 Describe any efforts used to educate members of available behavioral health services. Also, describe education efforts to medical providers and facilities of your behavioral health services so that members who could benefit from those services can be referred if presenting at a medical provider.

1000 words.

5.18.4 Are specialty case managers used to manage Mental Health/Substance Use Disorder cases? What are their credentials?

Single, Radio group.

1: Yes, explain: [500 words] ,

2: No

5.18.5 Do Mental Health, Substance Use Disorder case managers routinely co-manage cases with medical and/or disease management case managers?

Single, Radio group.

1: Yes, explain: [500 words] ,

2: No

5.18.6 Does the same case manager handle the member's care through all levels of care? For example, inpatient, intermediate, and outpatient?

Single, Radio group.

1: Yes, explain: [500 words] ,

2: No

5.18.7 How long is a patient monitored after discharge?

1000 words.

5.18.8 What guidelines do you use to ensure appropriateness of treatment (utilization and duration for relevant medications and services)?

1000 words.

5.18.9 Depression is often diagnosed as a comorbidity with certain chronic conditions such as diabetes, heart disease etc. Please describe how you manage these situations.

1000 words.

5.18.10 Please describe how you will coordinate and integrate with the State's existing chronic disease management program administrator, CMSI, to ensure seamless care coordination of chronic disease management and behavioral health needs.

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1000 words.

5.18.11 Do any primary care practices in your network have a mental health professional on site that can perform depression screenings and evaluate whether a patient is in need of behavioral health services? If so,

a. Describe the behavioral health and/or depression screening programs.

b. How are claims coded for these services?

c. Are these services typically covered as part of preventive services, treatment of an illness, or not covered?

d. Are services covered separately as part of a single visit?

Single, Radio group.

1: Yes, explain: [1000 words] ,

2: No

5.18.12 Confirm you offer a comprehensive behavioral health network that includes a variation of providers such as Psychiatrists (MDs), Psychologists, therapists, Counselors, Social Workers, DEA waiver providers, ABA Paraprofessionals, etc.

Single, Radio group.

1: Confirmed, please explain: [500 words] ,

2: Not confirmed

5.18.13 What percentage of your behavioral health providers are accepting new patients?

Percent.

5.18.14 Across your book of business, for 2018, on average, how many days did it take for a first time patient to get an appointment with a behavioral health provider?

Decimal.

5.18.15 Describe your substance use disorder program.

1000 words.

5.18.16 Describe your (or your behavioral health subcontractor's) philosophy for best practice treatment for members with opioid addiction needing inpatient substance use services.

1000 words.

5.18.17 Describe any program you have to provide behavioral health services online or by telephone and specify the credentials held by those performing such services.

1000 words.

5.19 SPECIALIZED PROGRAMS AND NETWORKS

5.19.1 Do you currently work with clients to create clinical and utilization management programs for prescription drugs covered through the medical benefit? If yes, describe your programs.

1000 words.

5.19.2 Do you currently have contracted rates with network providers for drugs administered through the medical benefit? Do they include rebates?

1000 words.

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5.19.3 Are you able to work with the PBM to secure aggressive rebates on claims processed under the medical benefit? If so, please explain your process.

1000 words.

5.19.4 Describe your reporting and monitoring of prescription drugs administered through the medical benefit. What information is tracked? What patterns and trends do you monitor?

1000 words.

5.19.5 How will you prevent price increases for medications (such as oncology drugs or other infusions) that are administered through the medical benefit plan?

1000 words.

5.19.6 Describe your approach to providing telemedicine services (e.g., immediate service, care coordination with PCP providers, etc.), and the advantages/disadvantages of this approach.

1000 words.

5.19.7 Describe any drill down reporting to evaluate the effectiveness of telemedicine (i.e. subsequent office visits with same presenting diagnosis).

1000 words.

5.19.8 What adjustments, if any, have you made to your telemedicine benefit since inception to make it more successful in truly redirecting utilization by treating members effectively and to their satisfaction?

1000 words.

5.19.9 Describe how using telemedicine is consistent with and/or preferable to the current standard of care.

1000 words.

5.19.10 Describe your arrangement with the medical professional(s) providing telemedicine services by specialty type (employees, ownership, contract workers, etc.)

1000 words.

5.19.11 Complete the following chart for telemedicine providers. If services for a particular provider specialty are not provided, please indicate N/A:

Provider Type	Average Length of Employment	Number of Fulltime Employees	Number of Part-time Employees	Number of Contract Workers	Total Consults provided in 2018	Total Consults provided in 2017
Family/General Practice	<i>Decimal.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.
Nurse Practitioners	<i>Decimal.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.
Dermatology	<i>Decimal.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.
Mental Health Providers	<i>Decimal.</i>	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>

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	N/A OK.	N/A OK.	N/A OK.	N/A OK.	N/A OK.	N/A OK.
Internal Medicine	<i>Decimal.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.
Pediatrics	<i>Decimal.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.
Registered Dietician	<i>Decimal.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.	<i>Integer.</i> N/A OK.
Other:	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>

5.19.12 When a telemedicine provider determines a referral to a traditional brick and mortar practice is appropriate, confirm you will refer within the State's contracted provider network, if available.

Single, Radio group.

1: Confirmed, please explain: [Unlimited] ,

2: Not confirmed

5.19.13 Describe what services are included in a typical telemedicine consultation fee.

1000 words.

5.19.14 How do you differentiate and support low-risk versus high-risk pregnancies?

1000 words.

5.19.15 For each of the specialty programs listed below, provide a brief description of:

- i. your program
- ii. services
- iii. coverage available throughout the State of Connecticut
- iv. number of providers in Connecticut
- v. precertification requirements
- vi. how members are directed
- vii. how quality and cost efficiency are improved
- viii. how outcomes are tracked and measured
- ix. outcomes for 2017 and 2018

	Response
a. Opioid Management	<i>1000 words.</i>
b. Dialysis Management and Clinic Support	<i>1000 words.</i>
c. Oncology Management	<i>1000 words.</i>
d. Applied Behavioral Analysis (ABA) Management	<i>1000 words.</i>

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e. Discount Vision Program	1000 words.
f. Integrative Medicine	1000 words.
e. Other	1000 words.

5.20 VENDOR INTERFACES

5.20.1 Confirm you will share data with health benefits administrators and the State's healthcare consultant and actuary, data manager and other vendors as requested by the State.

1000 words.

5.20.2 Describe how data is integrated from various components of your solution or other employer-sponsored programs and services (e.g. Health Enhancement Program (“HEP”) a value-based insurance design, Rx, Centers of Excellence, etc.) to support your program(s).

1000 words.

5.20.3 Confirm your ability and willingness to share data in and out of your ecosystem, including:

Category	Description	Confirmed / Not Confirmed	Comments
EDI 270 Health Care Eligibility/Benefit Inquiry transaction set real time	Confirm you will provide an EDI 270 Health Care Eligibility/Benefit Inquiry transaction set in real time.	Single, Pull-down list. 1: Confirmed, 2: Not Confirmed, please explain	500 words.
Accumulator	Confirm you can support accumulators that integrate medical and prescription drug cost sharing to accumulate towards calculation of out-of-pocket maximums.	Single, Pull-down list. 1: Confirmed, 2: Not Confirmed, please explain	500 words.
Prior Authorizations	Confirm your organization can transmit a prior authorization 275 file to support integration with other employer-sponsored programs and services (e.g., Centers of Excellence, Rx.	Single, Pull-down list. 1: Confirmed, 2: Not Confirmed, please explain	500 words.

5.20.4 Does your program/system have the capability to share applicable data with the following vendors or programs?

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	Response
Biometrics	<i>Multi, Checkboxes.</i> 1: Will submit to third party vendors/programs, 2: Will accept from third party vendors/programs
Case Management	<i>Multi, Checkboxes.</i> 1: Will submit to third party vendors/programs, 2: Will accept from third party vendors/programs
Demand Management/Nurseline	<i>Multi, Checkboxes.</i> 1: Will submit to third party vendors/programs, 2: Will accept from third party vendors/programs
Disability	<i>Multi, Checkboxes.</i> 1: Will submit to third party vendors/programs, 2: Will accept from third party vendors/programs
Disease Management	<i>Multi, Checkboxes.</i> 1: Will submit to third party vendors/programs, 2: Will accept from third party vendors/programs
Behavioral Health	<i>Multi, Checkboxes.</i> 1: Will submit to third party vendors/programs, 2: Will accept from third party vendors/programs
Eligibility	<i>Multi, Checkboxes.</i> 1: Will submit to third party vendors/programs, 2: Will accept from third party vendors/programs
Maternity Management	<i>Multi, Checkboxes.</i> 1: Will submit to third party vendors/programs, 2: Will accept from third party vendors/programs
PBM	<i>Multi, Checkboxes.</i> 1: Will submit to third party vendors/programs, 2: Will accept from third party vendors/programs
Providers	<i>Multi, Checkboxes.</i> 1: Will submit to third party vendors/programs, 2: Will accept from third party vendors/programs
COE	<i>Multi, Checkboxes.</i> 1: Will submit to third party vendors/programs, 2: Will accept from third party vendors/programs
Health Advocacy and Navigation Services	<i>Multi, Checkboxes.</i>

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	1: Will submit to third party vendors/programs, 2: Will accept from third party vendors/programs
Others, please specify:	<i>Multi, Checkboxes.</i> 1: Will submit to third party vendors/programs, 2: Will accept from third party vendors/programs

5.20.5 How do you ensure that the State's information is treated distinct/separate from other customers' information? What protocols are in place within your company to ensure that only authorized individuals within your company can view and/or edit the State's information?

1000 words.

5.20.6 Describe how data is integrated from various components of your solution or other employer-sponsored programs and services (e.g. Health Enhancement Program (“HEP”) a value-based insurance design, Rx, Centers of Excellence, etc.) to support your program(s).

1000 words.

5.20.7 Describe how member cost-sharing is coordinated with and/or reported to other health or Pharmacy plans under contract with OSC.

1000 words.

5.21 DATA AND REPORTING

5.21.1 Describe capabilities are that are available to State staff through your employer portal (i.e., view eligibility changes and validate eligibility data, view claims, pull standard reports, create customized ad hoc reports, etc.)?

1000 words.

5.21.2 Indicate the reports you can provide on both a quarterly and an annual basis:

Multi, Checkboxes.

- 1: Financial Claim Update,
- 2: Utilization Review,
- 3: Network Utilization,
- 4: Clinical Review,
- 5: Preventive services,
- 6: Case Management,
- 7: Large Claimants,
- 8: Hospital Inpatient Review,
- 9: Maternity Program,
- 10: Other Programs

5.21.3 Detail the full package of available reports and indicate which reports are available to the State on-line.

1000 words.

5.21.4 Provide a sample of weekly detailed claims and enrollment data downloads including file layouts and documentation.

Single, Pull-down list.

- 1: Sample attached,
- 2: Sample not attached.

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5.21.5 Confirm that there is no additional cost for these reports and electronic data downloads as required by the State.

Single, Pull-down list.

1: Yes, please explain (500 words),

2: No

5.21.6 Describe the requirements on the user/client site to access your site (i.e. levels of passwords required for users to log onto the site).

1000 words.

5.21.7 Indicate the earliest possible availability of detailed claims data for analysis. Can your systems provide information to the State and its vendors about member utilization within 24 hours of occurrence?

1000 words.

5.21.8 What tools do you offer clients to spot and identify trends in claim information?

500 words.

5.21.9 Do you charge for ad hoc or customized reports? If so, please explain.

Single, Radio group.

1: Yes,

2: No,

3: Other, please specify: [500 words]

5.21.10 For the State and Partnership Plan, all reports must be stratified by Plan, and sub-stratified by: Actives, Retirees <65, Dependent <65, and Partnership. The Partnership groups must then be able to be stratified by individual groups and subgroups as set forth in the plan structure. Please confirm that you agree to this provision.

Single, Pull-down list.

1: Confirmed,

2: Not Confirmed

5.21.11 With regard to your computer systems, please describe your record retention and destruction policy, including how long records are retained.

Unlimited.

5.21.12 What types of security do you have with regard to your website and the transfer of data?

Unlimited.

5.22 MEHIP

Sec. 5 – 259 of the general statutes allows the Comptroller to offer health care coverage to municipalities, nonprofit corporations, community action agencies and small employers. Under this authority the Comptroller's Office has administered the Municipal Employee Health Insurance Program (MEHIP) since 2003. Currently MEHIP provides coverage, through small group plans offered by the state's Administrative Service Organizations to over 2,000 participants. The MEHIP program is administered by a third party administrator (TPA), currently Stirling Benefits. The current MEHIP design <http://www.ctmehip.com/benefit%20plans.html> is a splice program in which covered individuals of enrolled groups can choose from a menu of plan options

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including Health Savings Accounts (HSA) and Health Reimbursement Arrangements from two carriers. The TPA administers the billing and enrollment for the program. The Comptroller's Office is interested in expanding the utility of the MEHIP program for current and eligible enrollees by offering more competitive plans, and rates, while incorporating improved care management and wellness programs.

Consistent with past practice the winning bidder for ASO services for the state employee medical plan may be required to offer products through the MEHIP program as part of the required scope of services under their contract. A successful bidder may be required to offer plans through MEHIP. Please confirm your ability and willingness to do so. For this RFP, please indicate that you are willing to cover the MEHIP plan and match their program to that of the State. This RFP does not include a full evaluation of MEHIP at this time.

5.22.1 A successful bidder may be required to offer plans through MEHIP. Please confirm your ability and willingness to do so.

Single, Radio group.

1: Confirmed,

2: Not Confirmed

5.22.2 Would you be willing to work with the Comptroller's Office to develop additional plan designs?

Single, Radio group.

1: Yes,

2: No (please explain): [500 words]

5.22.3 The Comptroller's Office is interested in incorporating narrow and or tiered network plans in the MEHIP program that incorporate quality metrics in the network or tiering criteria to provide additional affordable options for enrollees. Please describe your strategy for developing narrow or tiered networks and the amount such products are able to reduce premiums versus similar broad network products. Please describe the criteria used to establish the network and how such criteria may lead to improved outcomes for plan participants as well as reduced total premium costs. The Comptroller's Office would like to see narrow or tiered network options that offer net premium savings of a minimum of 10% versus similar broad network plans.

1000 words.

5.22.4 The Comptroller's Office is in the process of developing a custom Centers of Excellence network for the State employee plan, would you be willing to incorporate the State's Center of Excellence network, including leveraging the state's improved negotiated rates, into some or all of your MEHIP product offerings?

1000 words.

5.22.5 Please describe your marketing and outreach plan to expand the reach of the MEHIP program beyond current membership. Please describe how you would partner with the Comptroller's office to expand enrollment in the MEHIP program.

1000 words.

5.23 AUDITS

5.23.1 Once each year, or more frequently as reasonably determined by the State, or within two (2) years following termination of this Agreement, Client's third party Auditor(s) ("Auditor"), as reasonably approved by Vendor (which approval shall not be unreasonably withheld), may inspect and verify claim data, eligibility, billing records, pricing discounts and terms, claims adjudication systems, healthcare benefits, clinical programs, subcontracted administrative services directly related to Client's Member utilization and services, performance

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guarantees, and operational processes relating to the services provided to Client pursuant to this Agreement to ensure Vendor's compliance with the terms and conditions of this Agreement, as Client deems appropriate.

Single, Radio group.

- 1: Agree,
- 2: Disagree

5.23.2 Such audits may be based on either a 100% review of claims or a statistically representative sample thereof, or combination of methodologies. Auditor's preliminary findings will be shared with Vendor. Any findings from a statistically representative sample of claims will be extrapolated to the total claims population for purposes of measuring overall financial dollar and incidence processing achievements; Vendor will produce financial impact reports for confirmed systemic errors. In the instance where Auditor has reviewed 100% of claims and identified suspect claims, Vendor may elect to review a mutually-agreed upon representative sample of the suspect claims.

Single, Radio group.

- 1: Agree,
- 2: Disagree

5.23.3 The audit may include an onsite review of the sample claims by the Auditor at Vendor's office. The Auditor will provide Vendor with the sample claims thirty (30) calendar days in advance of the onsite review. The onsite review will last up to five (5) business days.

Single, Radio group.

- 1: Agree,
- 2: Disagree

5.23.4 Confirm the scope of such audits may include up to three (3) benefit plan years as determined by the State.

Single, Radio group.

- 1: Agree,
- 2: Disagree

5.23.5 Indicate whether you agree with the following statements regarding audits.

	Response
You will allow auditing of your operations as they relate to the administration and servicing of this account.	<i>Single, Radio group.</i> 1: Agree, 2: Disagree
Your organization will not charge for services rendered in conjunction with the audit.	<i>Single, Radio group.</i> 1: Agree, 2: Disagree
If problems are discovered, the cost of follow-up audits will be paid by your organization.	<i>Single, Radio group.</i> 1: Agree, 2: Disagree
Vendor agrees to fund up to \$35,000 for a pre-implementation audit.	<i>Single, Radio group.</i> 1: Agree,

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2: Disagree

5.23.6 The State via its auditor has the right to perform additional audits during the year of similar scope if performed as a follow-up to ensure significant/material errors found in a previous audit have been corrected and are not recurring or if additional information becomes available to warrant further investigation.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.23.7 The State via its auditor has the right to audit post termination of service contract.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.23.8 Your organization will provide a response to all findings received within 30 days of audit, or at a later date if mutually determined to be more reasonable based on the number and type of findings.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.23.9 Confirm you will allow Segal Consultants, or any other party selected by the State to audit all provisions governed by the contract.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.23.10 Confirm you agree not to charge the State for EOBs/claims issued as corrections due to audits.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.23.11 Any and all costs and expenses of each party associated with State's audit shall be borne by the party incurring the cost. the parties agree that the scope of audits by Client or Auditor will not be duplicative of the SSAE-18 audit, but may include inspection and/or verification of certain information provided in the SSAE-18 audits to the extent necessary to give a more thorough understanding of and support for such information. Audit materials or documentation provided by Vendor will be confined to client-specific information. Confirm your agreement with this provision.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.23.12 If the audit discovers any validated overpayment of fees or claim payments by Vendor or other errors that result in economic losses to the client for failure to meet all vendor guarantees or performance standards, then Vendor shall pay the amount owed to the State following completion of the audit, within 30 days of written confirmation from the client as to the agreed upon settlement terms and amounts. Confirm your agreement with this provision.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

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5.23.13 Vendor agrees to grant the right of the State or its representative(s) to audit claims at any time during and up to two years following termination of the business relationship with prior written notification. The State will have access to 100% of all valid claim records to complete the audit at no cost to the plan sponsor. Bidder agrees to provide all necessary claims details, data definitions and reasonable support to complete an independent claim audit for each completed year under the contract in effect. The State will not be held responsible for time or miscellaneous costs incurred by the bidder in association with an audit including, but not limited to, the costs associated with providing audit reports, systems access, or onsite space.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.24 FINANCE AND BANKING

5.24.1 What data/electronic information is needed to coordinate billing between you and the State for services provided?

500 words.

5.24.2 The State makes payment in arrears, provides claims reimbursements twice per month, and administrative fees once per month at the end of the month. Confirm you will adhere to this schedule.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.24.3 Do you require that self-funded plans use a specific bank for funding claims? If yes, indicate the name of the bank.

Single, Radio group.

- 1: Yes [500 words] ,
- 2: No

5.24.4 What payment options are available to the State? 1: ACH, 2: Wire transfer

Single, Radio group.

- 1: Other: [500 words]

5.24.5 Confirm you will not charge interest on negative cash flow for any delay of wire transfer.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

5.24.6 Confirm that the State will not be charged for reissued checks or drafts.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

5.24.7 Confirm that you will accept fiduciary responsibility for claims processing at no additional charge.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed:

5.24.8 Do you require an initial deposit and/or imprest amount?

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Single, Radio group.

- 1: Initial deposit only,
- 2: Imprest amount only,
- 3: Both

5.25 IMPLEMENTATION SUPPORT

5.25.1 Provide a detailed implementation plan assuming an implementation date of July 1, 2020. At a minimum, the implementation plan must provide specific details on the following:

1. Identification and timing of significant responsibilities and tasks for the State and Vendor
2. Names, titles, and implementation experience of key implementation staff and time dedicated to the State during implementation
3. Data Interfaces – the Vendor will be required to transmit and receive data to and from the State and its vendors as outlined in this RFP and as determined necessary by the State.
4. Transition requirements with the incumbent vendor(s), including data needs and timing for transition of care (PA, current maternity cases, transplant patients, etc.)
5. Member communication plan
6. Issuance of I.D. Cards
7. Completion of Vendor Contract

Single, Radio group.

- 1: Attached,
- 2: Not attached, explain: [500 words]

5.25.2 Confirm that, if awarded the business, you will be prepared to start implementation work as of the contract award date due to the lead-time needed for open enrollment.

Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed

5.25.3 Confirm your organization will provide weekly updates and/or meetings detailing all implementation activities and status including a Final Report.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

5.25.4 Are you willing to provide a one-time implementation allowance to fund, as approved by the State, implementation support, pre-implementation audits, readiness assessments, communication plans, outside printing costs, etc., for the Medical Plans? If so, what dollar amount are you willing to provide?

Single, Radio group.

- 1: Confirmed, please specify amount: [Dollars] ,
- 2: Not Confirmed

5.25.5 Identify the implementation team you propose to work on this account and provide an organization chart defining the implementation team roles. Include names, titles, experience and qualifications for the entire proposed implementation team including key positions and support staff.

1000 words.

5.25.6 Does your Implementation Team conduct pre-implementation and post-implementation testing?

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Single, Radio group.

1: Yes,

2: No, explain [500 words]

5.26 FINANCIAL SECTION AND NETWORK ACCESS

All responses are due in the electronic Excel format provided.

5.26.1 Administrative Services Only Fees

5.26.1.1 Confirm completion of the Administrative Services Only Fees Chart in the attached Excel spreadsheet assuming a July 1, 2020 effective date. Fees are requested for July 1, 2020 through June 30, 2023 with the option for July 1, 2023 and July 1, 2024. Fees should be on a per subscriber (contract) per month basis. Please provide answers only as applicable for quote. Fees must be shown in the format provided. Alternatives may be considered. **[See “1. Administration” tab in State of CT - July 1, 2020 RFP Attachment File.xlsx]**

Your fees should be inclusive of all implementation costs. Note if fees will vary based on the size of the population. (i.e. If State chooses multiple bidders to administer benefits for State employees and/or Partnership Plan)

Single, Radio group.

1: Attached,

2: Not provided

5.26.2 Self-Funded Mature Expected Claims

5.26.2.1 Confirm completion of the Self-Funded Projected Claims chart in the attached Excel spreadsheet. Provide the mature expected claims per employee per month for the State and Partnership plans separately. **[See “2. Self-Funded Claim Pick” tab in State of CT - July 1, 2020 RFP Attachment File.xlsx]**

Single, Radio group.

1: Attached,

2: Not provided

5.26.3 Claim Costs - Provider Reimbursement & Discounts

This section refers to spreadsheets that must be completed based on the current network provider contracts and experience. Worksheets should be completed separately for select locations or for a composite of all network areas (if specific location is not requested).

5.26.3.1 Physician Reimbursement

5.26.3.1.1 Physician Discount Analysis. Confirm completion of this spreadsheet for network physicians. Provide your current (as of September 1, 2019) average physician discounts negotiated in Connecticut (all counties/all areas) as well as your average physician negotiated discounts specific to each county in CT. These discount percentages must be based on actual achieved discounts and should not be based on projected or expected discounts. **[See “3.1 Physician Discount” tab in State of CT - July 1, 2020 RFP Attachment File.xlsx]**

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IMPORTANT NOTE: All Physician Discounts should represent Global, Non-Facility Reimbursements. For services such as Radiology, the average discount should be based on both the professional fee and the technical fee components combined. DO NOT PROVIDE PROJECTED OR EXPECTED DISCOUNT PERCENTAGES.

Single, Radio group.

1: Attached,
2: Not provided

5.26.3.2 Hospital and Outpatient Facility Charges

5.26.3.2.1 Hospital Discount Analysis. Confirm completion of this spreadsheet for network hospitals. Provide your current (as of September 1, 2019) average inpatient and outpatient hospital discount negotiated in Connecticut (all counties/all areas) as well as your average physician negotiated discounts specific to each county in CT. [See “3.2 Hospital Discount” tab in State of CT - July 1, 2020 RFP Attachment File.xlsx]

DO NOT PROVIDE PROJECTED OR EXPECTED DISCOUNT PERCENTAGES.

Single, Radio group.

1: Attached,
2: Not provided

5.26.3.2.2 Describe how network hospitals are reimbursed. Your answer should be consistent with the fees provided on the spreadsheets provided. If reimbursement varies by geographic location, identify reimbursement arrangements by area for those relevant to the plan sponsor. Also note ANY variation in average discounts for larger claims over a certain threshold by identifying the threshold and the impact those contractual arrangements have on the discounts.

1000 words.

5.26.3.3 Claims Re-Pricing Analysis

5.26.3.3.1 Please re-price the claims provided in the detailed claims experience files referenced in the Appendix. There are repricing files for Inpatient, Outpatient, and Professional claim types for the State Anthem population, State Oxford population, and Partnership Oxford population. The re-pricing should be based on eligible charges (column “Eligible Amount” on the re-pricing claims files) and your current (as of September 1, 2019) network provider contractual fee arrangements. **The claims re-pricing amounts shall be based on actual data and shall not include any assumptions regarding projected discounts or assumed increases in billed charges.**

Provide the sum of all re-priced claims by category (Inpatient, Outpatient, Professional) and by in-network and out-of-network based on the eligible charges in the column “Eligible Amount”. Provide a reconciliation that ties the claims re-pricing back to the total eligible charges provided. [See claims repricing files] Your re-priced claim amounts should be stated in the “3.3 Claims Repricing” tab in the file **State of CT - July 1, 2020 RFP Attachment File.xlsx**

Please confirm:

Single, Radio group.

1: Attached,
2: Not provided

5.26.3.3.2 Provide the estimated attribution payments, estimated additional reimbursements for Provider Risk Sharing Arrangements, and any additional fees paid to vendors or providers that run through claim payment

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account based on the State and Partnership population. The amounts should be stated in the "3.3 Claims Repricing" tab in the file **State of CT - July 1, 2020 RFP Attachment File.xlsx**

Please confirm:

Single, Radio group.

- 1: Attached,
- 2: Not provided

5.26.3.3.3 Provide an explanation detailing how the claims were repriced, noting any and all adjustments and methodologies.

1000 words.

5.26.3.3.4 Confirm your re-pricing is based on your current network provider contractual fee arrangements. "Current" is defined as the discounts the State would achieve through your network as of September 1, 2019. The re-repriced amounts should reflect what you would have paid a provider if the claim was incurred on September 1, 2019. The repriced amounts should also include any and all fees paid to providers for ACOs and other risk-sharing arrangements with providers.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.26.3.3.5 Confirm your re-pricing is based on actual data and does not include any assumptions regarding projected discounts or assumed increases in billed charges.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.26.3.3.6 Confirm that you have provided an explanation summarizing how you re-priced claims, noting any and all adjustments and methodologies.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.26.3.3.7 Confirm you have not omitted any adjustments or methodologies from your explanation on how you re-priced the claims.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.26.3.3.8 Confirm that you have provided the claims reconciliation for all charges provided in the claims file.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.26.3.4 Network Discount Guarantee

5.26.3.4.1 Network Discount Guarantee - the guarantee should be structured so that your organization will be providing a guarantee based on a specific percentage (clearly stated as "the provider discounts realized by the State will be a minimum of X%") with a risk-free corridor of 1%. You will need to put a minimum of 10% of your

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fees at risk for this guarantee, and guarantees will be evaluated based on both the percentage discount and the dollars at risk. The formula for the discount measurement would be:

- a. Total of all facility and professional provider submitted charges (excluding all ineligible charges, duplicate claims, non-covered benefits and any coordination of benefits) = Covered Billed Charges
- b. Covered Billed Charges minus Cost of Benefits (after negotiated provider discounts but before employee copays and cost-sharing) equals Network Savings prior to plan design
- c. Network Savings prior to plan design divided by Covered Billed Charges = Guaranteed % Savings

You must enter the guaranteed percentage in cell F7 of the Network Discount Guarantee chart. [See “3.4 Discount Guarantee” tabs in State of CT - July 1, 2020 RFP Attachment File.xlsx]

Confirm completion of discount guarantee in format requested:

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.26.3.5 Contracted Future Discounts with Dollar for Dollar Guarantees

5.26.3.5.1 Reflect your contracted future discounts for the year beginning July 1, 2020 by completing the “3.5 Future Discount” tab in the **State of CT - July 1, 2020 RFP Attachment File.xlsx**. Include the annual dollar amount that you are willing to put at risk on a dollar-for-dollar basis for not achieving your contracted future discount.

Bidders' contracted future discounts should only reflect contracts with providers that have already been executed at the time of their proposal submission. Bidders should **not** reflect expected contracts that have **not** been executed as of the date of their proposal submission.

A bidder's current average discount (as of September 1, 2019) will be adjusted to reflect expected future average discount improvements up to the amount the bidder is willing to put at risk for year beginning July 1, 2020. Please see the following examples of the future discount adjustment assuming aggregate billed charges of \$100 million:

	Example #1		Example #2	
	Percent Off of Billed Charges	Discounted Claims (in millions)	Percent Off of Billed Charges	Discounted Claims (in millions)
Repricing Analysis Current Discount (As of 9/1/2019)	40%	\$60	40%	\$60
Bidder's Expected Discount Improvement (from spreadsheet in Excel file)	2%	-\$2	2%	-\$2
Expected Contracted Future Discount (As of 7/1/2020)	42%	\$58	42%	\$58
Proposed Amount at Risk	Dollar-for-Dollar up to \$2 million at Risk		Dollar-for-Dollar up to \$1 million at Risk	
Example Calculation	\$60 - \$2 = \$58		\$60 - \$1 = \$59	

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	Example #1		Example #2	
	Percent Off of Billed Charges	Discounted Claims (in millions)	Percent Off of Billed Charges	Discounted Claims (in millions)
	1 - \$58 / \$100 = 42%		1 - \$59 / \$100 = 41%	
Estimated and Guaranteed Discount for YB July 1, 2020	42%		41%	

Confirm completion of future discount guarantee in format requested:

Single, Radio group.

1: Confirmed,

2: Not confirmed

5.26.3.6 Claims Trend Guarantee

5.26.3.6.1 Provide the non-Medicare participant (active and retiree plans) claims trend your organization is willing to guarantee for each year of the contract by completing the “3.6 Trend Guarantee” tab in the **State of CT - July 1, 2020 RFP Attachment File.xlsx**. Your guarantee should state the percentage of your administration fee that will be at risk.

Trend guarantee will be based on the following methodology:

- The trend guarantee will apply to all claims incurred through all medical plans administered by the selected carrier for all non-Medicare participants (active and retiree plans).
- The actual 2020 incurred claims number will be measured using medical claims that were incurred during the fiscal year beginning July 1, 2020 and paid during that fiscal year and a six-month run-out period through December 2021, removing claims in excess of \$250,000. This total will be divided by the actual enrollment during the policy year. (Same methodology applies for fiscal years beginning July 1, 2021 and 2022.)
- The actual 2019 incurred claims number will be measured using medical claims that were incurred during the fiscal year beginning July 1, 2019 and paid during that fiscal year and a six-month run-out through December 2020, removing claims in excess of \$250,000. This total will be divided by the actual enrollment during the policy year. All the necessary supporting claims and enrollment data for the fiscal year beginning July 1, 2019 will be obtained by the State from its current medical administrator and provided to the Contractor.
- Claims will include the amounts that are the responsibility of both the member and the employer to mitigate distortions created by plan design changes. The actual 2020 trend will be calculated by dividing the adjusted 2020 incurred claims per member per month (calculated as described above) by the adjusted 2019 incurred claims per member per month (calculated as described above) less 1. (Same methodology applies for years beginning July 1, 2021 over 2020 and for 2022 over 2021.)
- A member continuously enrolled 12-months would count as 12-member months.

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Confirm completion of future discount guarantee in format requested:

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.26.3.7 ACOs

5.26.3.7.1 Confirm completion of the ACOs chart in the attached Excel spreadsheet. [See “3.7 ACO Chart” tab in State of CT - July 1, 2020 RFP Attachment File.xlsx]

Single, Radio group.

- 1: Attached,
- 2: Not provided

5.26.3.8 Network Access

5.26.3.8.1 Confirm completion of network disruption analysis. Indicate with a “Y” for Yes and “N” for No whether the Providers (physicians and hospitals) are in your proposed medical network [See State of CT - July 1, 2020 RFP Network Disruption File.xlsx]

NOTE: If the same provider is listed multiple times, you must provide a “Y” or “N” response for each individual record on each of the tabs. You cannot make any assumptions, the “Y” or “N” response needs to be specific to that provider, not to a category of providers. Tax ID is included in the Provider Disruption Reports.

Single, Radio group.

- 1: Attached,
- 2: Not provided

5.26.3.8.2 Confirm completion of geographic access analysis. Summarize your network access reports for your proposed medical network for State and Partnership employees separately. [See “3.8 Network Access GEO” tab in State of CT - July 1, 2020 RFP Network Disruption File.xlsx]

Single, Radio group.

- 1: Attached,
- 2: Not provided

5.26.3.9 Uniform Data Submission (UDS) Database Discount Comparison

5.26.3.9.1 The Uniform Data Submission workgroup is a collaborative effort to reach consensus on the definition of financial terms, claims categories, and general methodology of data files prepared and sent to consulting firms for discount comparison.

Segal receives the data files semi-annually (calendar year and mid-year). The files include 12 months of incurred claims experience for each carrier's entire commercial book of business, including two months of run-out. Capitation, surcharges, and network access fees are excluded.

Segal has developed a proprietary method of analyzing the data that has been approved by all participating carriers. **Please indicate below that you agree to the use of our UDS database in this analysis (action required).**

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We acknowledge Segal will use their UDS database to perform a network discount comparison. Segal's results will be validated with each carrier prior to the release of the analysis to the State.

Single, Radio group.

1: Confirmed,

2: Not confirmed

5.26.3.9.2 To complete our discount analysis using the UDS data, please answer the questions below:

	Response
Which network should be used in the database? Do we need to combine any networks in certain locations? Or use one network for [Region 1] and another for [Region 2]?	500 words.
Is there anything outside of the UDS system we should know about?	1000 words.
Based on the outcome of this task force, Segal will use UDS data to analyze network discounts as part of our standard methodology to perform a discount analysis. If you are not currently part of the UDS Task Force, would you be willing to provide Segal with data in an agreed upon format on behalf of the State? If yes, please contact us and we will provide the data requirements and record layout.	1000 words.

5.26.4 Services and Fees Related to Federal and State Mandates

5.26.4.1 Please confirm (Yes or No) whether you will provide the following services related to federal and state mandates on behalf of the State for all of the benefits/plans outlined in this RFP. For each service, indicate if there is an extra charge for providing this service. Please provide additional comments, if necessary.

	Service Provided	Fee	Additional Comments
Tracking and reporting member counts for:			
a. CT Pediatric Immunization Fee	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Dollars.</i> N/A OK.	<i>500 words.</i>
b. Out-of-State Fees and Surcharges (i.e. NY Surcharge, etc.)	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>Dollars.</i> N/A OK.	<i>500 words.</i>
Payment on behalf of the State for:			
a. CT Pediatric Immunization Fee	<i>Single, Pull-down list.</i>	<i>Dollars.</i> N/A	<i>500 words.</i>

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	1: Yes, 2: No	OK.	
b. Out-of-State Fees and Surcharges (i.e. NY Surcharge, etc.)	<i>Single, Pull-down list.</i> 1: Yes, 2: No	Dollars. N/A OK.	500 words.

5.27 PERFORMANCE GUARANTEES

Note: Measurement of satisfaction of performance guarantees may be based on internal self-reporting, but is subject to independent audit by the State or its designee.

5.27.1 Confirm completion of Performance Guarantees in **State of CT - July 1, 2020 RFP Attachment File.xlsx**.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

5.27.2 Provide other guarantees on Performance Guarantees **State of CT - July 1, 2020 RFP Attachment File.xlsx** in that you are willing to include in a contract. List standards, measures, and range of penalties and incentives to which you are willing to agree to.

Single, Radio group.

- 1: Agree,
- 2: Do Not Agree

6 BID EXCEPTIONS AND DEVIATIONS

6.1 If your bid does not fully comply with the specifications in this Request for Proposal (RFP), please complete and upload the Bid Exceptions and Deviations Document.

Single, Radio group.

- 1: Bid does not fully comply - Document Attached,
- 2: Bid does fully comply - Document Not Attached

Attached Document(s): [SOC_F - Bid Exceptions & Deviations Form.DOCX](#)

7 APPENDIX

7.1 Attachments

A - Intent to Bid Form.docx

All bidders must complete Attachment A – Intent to Bid and email by 2 PM EST on September 30, 2019 to:

Emily K. Peters
 Segal Consulting
 Email: epeters@segalco.com

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- B - Non-Disclosure Agreement.docx**
- C - Std. Terms and Conditions.docx**
- D - Contractors Guide to the Code of Ethics (rev Jan2019).pdf**
- E - OPM Ethics Form 6 (Final 9-15-11).docx**
- F - Bid Exceptions & Deviations Form.docx**
- G - Eligibility File Feed Requirements.pdf**
- H - File Layout Remedy 09-2019.xlsx**
- I - Form 11 SEEC.pdf**

Attached Document(s): [SOC - D Contractors Guide to the Code of Ethics \(rev Jan2019\).PDF](#), [SOC - E OPM Ethics Form 6 \(Final 9-15-11\).DOCX](#), [SOC A - Intent to Bid Form \(1\).DOCX](#), [SOC B - Non-Disclosure Agreement \(1\).DOCX](#), [SOC C - Std. Terms and Conditions.DOCX](#), [SOC F - Bid Exceptions & Deviations Form.DOCX](#), [SOC G - Eligibility File Feed Requirements.PDF](#), [SOC H - File Layout Remedy 09-2019.XLSX](#), [SOC I - Form 11 SEEC.PDF](#)