Addendum 1

Medicaid Quality Improvement and Shared Savings Program
Participating Entities Request for Proposals
MQISSP_RFP_060616

The State of Connecticut Department of Social Services is issuing **Addendum 1** to the Medicaid Quality Improvement and Shared Savings Program Participating Entities Request for Proposals.

Addendum 1 contains:

A. Amendments to the original RFP issued on June 6, 2016

B. Questions and Responses

A. Amendments to the original RFP issued on June 6, 2016

1. The first amendment to the original RFP in SECTION III PROPOSAL INFORMATION
F. MQISSP PARTICIPATING ENTITY REQUIREMENTS

3. Enhanced Care Coordination Activities

e. Children and Youth with Special Healthcare Needs[1] (CYSHCN): Age 0–17 Years

i. Require advance care planning discussions for CYSHCN. Advance care planning is not limited to CYSHCN with terminal diagnoses. It can occur with CYSHCN with chronic health conditions, including behavioral health conditions, that significantly impact the quality of life of the child/youth and his/her family.

ii. Develop advance directives for CYSHCN.

iii. Include information from other services that child uses in the health assessment and health information record: Such information includes:

- ~~s~~School information including school-based health center: ~~related information in the member's health assessment and health record, such as: the~~ individualized education plan or 504 plan, special accommodations, assessment of patient/family need for advocacy from the provider to ensure the child's health needs are met in the school environment, how the child is doing in school and how many days have been missed due to the child's health condition, and documenting the school name and primary contact.

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[1] Maternal Child and Health Bureau definition of CYSHCN: "Those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. " This definition is broad and inclusive, and it emphasizes the characteristics held in common by children with a wide range of diagnoses. Examples include children with diagnoses such as diabetes or asthma that is not well controlled. http://mchb.hrsa.gov/cshcn05/

- Early intervention information: including individualized family service plan, evaluation results and other documentation of early intervention services
- Home visiting information: including documentation of screening results, needs identified and services provided
- Early care and education (ECE) information: including Head Start and other early care programs, screening results, accommodations made and general coordination of care with ECE health consultants
- Child welfare information: including multidisciplinary assessments and services
- Behavioral health information: including screening, evaluations and services
- Disability services information
- In addition to the information above, practices that service CYSHCN will coordinate and document care using the following resources:
- The Department of Public Health medical home initiative for CYSHCN, which includes regional care coordination entities to assist medical homes in caring for and meeting the needs of CYSHCN and their families
- Training and other programs offered through the DPH regional care coordination collaboratives for CYSHCN
- Participation in scheduled case reviews with CHN and the CYSHCN program
- Family respite services offered through the CYSHCN program
- United Way's 211 Child Development Infoline and Help Me Grow services to connect CYSHCN to parent support and other community services
- Shared Plan of Care (SPoC) developed by DPH CYSHCN program in collaboration with CHN for promoting coordination of services for CYSHCN.

2. The second amendment to the original RFP in SECTION III PROPOSAL INFORMATION

E. PROGRAM DESCRIPTION

2. Retrospective Attribution and Prospective Assignment Methodology
Eligible Medicaid beneficiaries (as described in Section III.E.1) will be assigned to MQISSP Participating Entities using DSS' existing Medicaid retrospective attribution methodology that is used for Medicaid participating primary care providers and also ~~in Connecticut's Medicaid program (and is also the attribution methodology used for the~~ Person Centered Medical Home

(PCMH practices ~~program)~~, adapted as necessary for MQISSP. The ~~PCMH~~ Medicaid retrospective attribution methodology attributes a Medicaid beneficiary to a PCMH based on the beneficiary's active choice of provider (i.e., usual source of care). An MQISSP Participating Entity's attributed beneficiaries are the beneficiaries assigned to its PCMH practices using this methodology. Even if the organizational structure of an MQISSP Participating Entity includes other providers, only the beneficiaries assigned to ~~a~~ PCMH practices affiliated with the MQISSP Participating Entity will be considered to be the MQISSP Participating Entity's beneficiaries. Once beneficiaries have been attributed to PCMH practices through the above process, DSS will assign them prospectively to those practices for purposes of identifying the panels of beneficiaries for which they are responsible during the MQISSP contract period. Eligible Medicaid beneficiaries will be assigned to only one MQISSP Participating Entity. Eligible Medicaid beneficiaries will be assigned to an MQISSP Participating Entity ~~on or around September 30, 2016~~ in due time for the Performance Year starting January 1, 2017.

Beneficiaries will not be "enrolled" with an MQISSP Participating Entity. MQISSP Members will retain the ~~ability~~ right to choose to see any qualified Medicaid provider. Members will be notified of this right by DSS through an ~~established~~ formal notification process. MQISSP Members will continue to be eligible for all services covered by the Connecticut Medicaid program, including those not included in the shared savings calculation.

Eligible Medicaid beneficiaries will have the ~~ability~~ right to opt-out of prospective assignment to MQISSP. An eligible Medicaid beneficiary ~~can~~ has the right to opt-out either before the implementation date of MQISSP or at any time throughout the Performance Year. If an eligible Medicaid beneficiary opts-out of MQISSP, then that beneficiary's~~ies'~~ claim costs will be removed from the assigned MQISSP Participating Entity's shared savings calculation and quality measurement. If an eligible Medicaid beneficiary opts-out of the MQISSP and that beneficiary's assigned MQISSP Participating Entity was an FQHC, then that FQHC will no longer receive the Care Coordination Add-On Payment for that beneficiary.

DSS is ~~working to~~ developing a process and tools to notify beneficiaries of the rights, benefits and risks of participating in MQISSP, including, but not limited to, prospective assignment status, care coordination benefits, shared savings arrangements, and opt-out provisions.~~eligible for prospective assignment to MQISSP Participating Entities about MQISSP and their prospective assignment status. Participating Entities will be notified ahead of assignment.~~

3. The third amendment to the original RFP in SECTION V PROPOSAL OUTLINE:

~~V~~IV. PROPOSAL OUTLINE

4. The fourth amendment to the original RFP in V. ATTACHMENTS, A. MQISSP QUALITY MEASURE SET, found on page 57 is deleted in its entirety.

   V. ATTACHMENTS, A. MQISSP QUALITY MEASURE SET is found on page 58.

5. The fifth amendment to the original RFP, C. INSTRUCTIONS

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

RFP Released:	June 6, 2016
RFP Conference:	June 13, 2016
Deadline for Questions:	June 20, 2016, 2:00 pm Eastern Time
Answers Released (tentative):	June 30, 2016, Addendum 1
	July 7, 2016*, **Addendum 2**
NEW: Clarifying Questions Due:	July 12, 2016. 2:00 pm Eastern Time
Responses to Clarifying Questions:	July 14, 2016*, **Addendum 3**
Letter of Intent (LOI) Due:	July ~~12~~ 19, 2016, 2:00 pm Eastern Time
Proposals Due:	~~July 26~~ August 2, 2016, 2:00 pm Eastern Time
Start of Contract*:	**January 1, 2017**

Addendum 2 will contain the balance of the responses to questions, the MQISSP Conference Transcript and Sign-In Sheet and current Attributions by Setting.

The Department will respond to Clarifying Questions, of the responses to questions in Addendum 1 and Addendum 2, **in Addendum 3**, per schedule above.

B. Question and Responses:

Questions submitted by interested parties and the official responses follow. These responses shall clarify the requirements of the RFP.

In the event of an inconsistency between information provided in the RFP and information in these responses, the information in these responses shall control.

1. **Question**: How will Medicaid beneficiaries be assigned to MQISSP Participating Entities? Furthermore, how many will be assigned to each Participating Entity? (Page 4)

   Response: DSS will assign Medicaid beneficiaries to MQISSP Participating Entities for the contract year in advance, based on attribution of these individuals to PCMH practices using the Medicaid attribution methodology. For more detail, see Pages 32-33 of the RFP.

2. **Question**: What would a "readiness assessment" entail? (Page 5)

   Response: DSS will issue details concerning the readiness assessment in early Fall 2016.

3. **Question**: What are some examples of Advanced Networks? Could an FQHC also be an Advanced Network? (Page 7)

   Response: Please see Page 7 for examples of Advanced Networks. No, an FQHC cannot be an Advanced Network.

4. **Question**: The RFP is for a one-year contract (Jan. 1, 2017 through Dec. 31, 2017). Will there be an opportunity for successful Participating Entities to renew their contracts annually?

   Response: The State Innovation Model (SIM) model test grant application commits the state to two waves of MQISSP. In mid-2017, DSS expects to issue an RFP for a contract period starting January 1, 2018. This RFP will be open to Participating Entities that are selected to participate via this RFP, as well as new applicants.

5. **Question**: The Executive Summary requires numerous attachments (Supporting Documentation, Acknowledgment Statements, FQHC Statement). Should these documents go directly after the Executive

Summary in the grant application? The Proposal Outline does not indicate where these attachments should go. (Pages 15, 16, and 55)

Response: Yes, please insert the required attachments, *labeled appropriately*, directly after the Executive Summary, as instructed in the RFP.

6. **Question**: According to Page 17, tab sheets are meant to separate each subsection of the MQISSP proposal (A. Cover Sheet; B. Table of Contents; C. Claim of Exemption from Disclosure; etc.). Are they also supposed to separate further subdivisions (F. Main Proposal 1. Organization; F. Main Proposal 2. Enhanced Care Coordination Activities…; F. Main Proposal 3. Quality; etc.)?

   Response: Tab sheets or tabs should separate the bolded sections, A-H, identified in IV. PROPOSAL OUTLINE. Tabbing numeric subdivisions is left up to the Respondents' discretion.

7. **Question**: Are there any page limits for sections other than the Executive Summary?

   Response: No. However, as noted on Page 49, DSS is encouraging respondents to be as brief as possible while also responding fully to all questions/requirements.

8. **Question**: Does the Workplace Analysis Affirmative Action Report (WAARP) need to be uploaded to the DAS automated system prior to submission or prior to receiving a contract? The WAARP is mentioned in the RFP but not as one of the required documents in the Proposal Outline. (Pages 23, 24, 55, and 56)

   Response: Per Section II. MANDATORY PROVISIONS, E. STATUTORY AND REGULATORY COMPLIANCE:

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

IMPORTANT NOTE: **The Respondent shall upload** the Workplace Analysis Affirmative Action Report through an automated system hosted by

the Department of Administrative Services (DAS)/Procurement Division, and the Department of Social Services can review said document online. The DAS guide to uploading affidavits and nondiscrimination forms online is embedded in this section as a hyperlink.

This requirement is in the IV. PROPOSAL OUTLINE, H. FORMS, 2. Other, a. Notification to Bidders, Parts I – V (CHRO), embedded as a hyperlink.

9. **Question**: What are the quality performance standards benchmarks and the measures of under-service MQISSP Participating Entities will have to meet? The RFP states that the measures of under-service are under development. When will they be available? (Page 33)

   Response: The current version of the quality performance standards, which are subject to modification in advance of the MQISSP implementation date, is included as Attachment A to the RFP.

   DSS's general approach to addressing under-service is described in the draft document entitled "Under-Service Utilization Strategy", dated September 30, 2016, which is available at this link, MQISSP-UNDER-SERVICE_UTILIZATION_MONITORING_STRATEGY. These strategies will continue to be expanded and refined.

10. **Question**: Are the nine quality measures mentioned on Page 36 the same as the quality performance standards referenced in our question above? In either case, what are those nine quality measures?

    Response: Yes, the quality measures referenced on Page 36 are the same as the quality performance measures referenced in Question 9 above.

11. **Question**: It appears that the copies of the three most recent financial statements that you want us to include only need to accompany the original proposal. Are we reading that correctly? Or should the five copies also include the financial statements? (Page 54)

    Response: Per Section G. MAIN PROPOSAL COMPONENTS,
    7. Financial Requirements
    A responsive proposal must include the following information about the Respondent's fiscal stability, accounting and financial reporting systems, and relevant business practices.

    a. Accounting/Financial Reporting

i. Provide assurance that the Respondent will comply with all Department accounting and financial reporting requirements.

b. Audited Financial Statements

i. Submit one copy each of the Respondent's three most recent annual financial statements prepared by an independent Certified Public Accountant, and reviewed or audited in accordance with Generally Accepted Accounting Principles. The copies shall include all applicable financial statements, auditor's reports, management letters, and any corresponding reissued components. Audited financial statements do not count toward the total page limit of the proposal. One copy only shall be included with the original proposal in Section V, Proposal Outline F.7.b.

Yes, you are reading the requirement correctly. It is only necessary to include the financial statements with the original copy of the proposal.

12. **Question**: It seems to me that this RFP is for health centers, NOT pharmacies. Can you confirm this? Also, are there any opportunities for pharmacies? We care currently contracted with CT Medicaid.

    Response: This RFP is only for FQHCs and for Advanced Networks. See Pages 42 through 45 of the RFP.

13. **Question**: I attended the RFP conference yesterday and we would be a wonderful partner for DSS in generating savings for the CT Medicaid program. We became an FQHC-Look-Alike two years ago and are in the process of applying to become a PCMH. We expect our application to be submitted by December. Would we be eligible to apply for the Medicaid Quality Improvement and Shared Savings Program? We would hate to miss this opportunity.

    Response: As indicated at the top of this Addendum, Responses to this RFP must be received on or before August 2, 2016.

    Within their responses, applicants must attest that they meet all of the requirements for an MQISSP Participating Entity, which are detailed on Pages 42 through 45 of the RFP. This includes, but is not limited to, documenting PCMH recognition as part of the RFP response.

    Please note that in mid-2017, DSS expects to issue an RFP for a contract period starting January 1, 2018. This RFP will be open to Participating Entities that are selected to participate via this RFP, as well as new applicants.

14. **Question**: Are MQISSP Participating Entities permitted to engage a subcontractor to perform required care coordination activities?

    Response: No, the MQISSP Participating Entity must provide required care coordination through individuals directly employed by, under contract to, or otherwise affiliated with the MQISSP Participating Entity. The purpose of this requirement is to ensure that care coordination is an essential part of the services provided by the MQISSP Participating Entity and that it is fully integrated into the day-to-day work of the Participating Entity.

15. **Question**: Can providers get access to data regarding their patients who have been admitted to psychiatric hospitals and/or substance use facilities?

    Response: State law, including chapter 899 of the Connecticut General Statutes, provides that psychiatric records are confidential and cannot be transmitted without appropriate consent. Further, federal regulations at 42 C.F.R. Part 2, establish that alcohol and drug treatment records cannot be disclosed without specified written consent. Current procedures enable primary practices to obtain access to DSS data regarding these records by requesting that their patients sign consent forms to disclose sensitive health information and sending these form to the medical ASO (Community Health Network of Connecticut, or CHNCT). DSS is exploring additional procedures to ensure compliance with applicable privacy requirements while also enhancing providers' ability to coordinate care.

17. **Question**: What, if any, savings does DSS project from implementing MQISSP?

    Response: DSS' hypothesis is that MQISSP care coordination activities and focus upon quality will improve both health outcomes and care experience, both of which have been demonstrated to contribute to cost savings. DSS has not made specific projections of the level of such savings. Please note that the method through which shared savings payments will be calculated, is described on Pages 35 through 38 of the RFP. As noted on page 36, savings will be based on expected cost trends, which will be developed from a comparison group.

18. **Question**: For providers other than primary care services, how can those providers be involved in MQISSP?

    Response: As described on Page 29, one of DSS's priorities with MQISSP is to further integration of behavioral health and primary care. The required care coordination activities listed on Pages 45-47 establish areas of focus, including, but not limited to, integration of primary care with behavioral health

and services for individuals with disabilities. Responses to this RFP must also document how an applicant proposes to implement and maintain meaningful partnerships with a wide variety of community partners, and how these partnerships will contribute to the respondent's capacity to effectively implement MQISSP.

DSS encourages providers to engage in dialogue with one other to foster and enhance the above referenced partnerships. DSS is assessing best means of fostering collaboration among providers.

19. **Question**: Following up on the bidders conference, as I want to be sure I/we receive any/all communications and addendums related to the referenced RFP. We do subscribe/receive the State's daily notices from the contracting portal. Is there anything else we should be doing to ensure receipt all RFP related information.

    Response: Subscribing to receive procurement email alerts on the State Contracting Portal is the most effective method to keep current with addenda to the RFP. The Department of Social Services website is also is updated for this purpose.

20. **Question**: Under 6.b.2, it states that only Ct. Medicaid enrolled providers may provide services. For the e-Consults program, is this also required? All eConsultants have a Ct. license but are unlikely to all be enrolled in Ct. Medicaid as they aren't being paid directly by Medicaid.

    Response: That statement in I.B.6.b.ii (on page 16 of the RFP) applies to providers directly employed by or under contract to the MQISSP Participating Entity. If the respondent is an FQHC that is participating in the e-consults program, the RFP does not intend to require that all of the eConsultant practitioners be enrolled in Medicaid because the eConsultant practitioners are typically affiliated with a subcontractor of the provider and are not directly affiliated with the provider. Related, as required by federal Medicaid law, all prescriptions, orders, and referrals for Medicaid services must be made by a Medicaid enrolled practitioner.

21. **Question**: When will we have the information about how much the prospective add on care coordination payment will be? (that is important in designing the program, particularly around additional staff)

    Response: DSS agrees that specific dollar amounts are important. As noted on page 11 of the RFP, the total state share funding available for the prospective care coordination add-on payments for FQHCs is $4,500,000 for calendar year 2017. Based on projected federal matching funds, the total

amount of payments is estimated to be approximately $10,000,000. Those funds will be paid out in equal per member per month (PMPM) amounts based on the total number of Medicaid beneficiaries who are eligible for MQISSP, whoare attributed to FQHC MQISSP Participating Entities and who do not opt out of MQISSP participation. DSS will not be able to confirm the final level of the care coordination payments until after the RFP selection process has been completed and after the attribution has been run again for all selected FQHC MQISSP Participating Entities,. Based on the current RFP schedule, it is anticipated that the payment amount is likely to be calculated around early November.

22. **Question:** Would the Department please provide a copy of the sample Part I of the standard contract per the instruction below?

- **A. STANDARD CONTRACT, PARTS I AND II**

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

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

Response: Because the RFP process is still pending, there is not yet any contract written regarding MQISSP. However, for sample standard contract language, you may view other, unrelated contracts on the DSS website at http://www.ct.gov/dss, click on "PARTNERS/VENDORS," then click on "CONTRACTS."

23. **Question**: Is the RFP Missing Section IV? I noticed that there are two sections labeled as Section V – one is "Proposal Outline" on page 55 but under Section III: Program Information; and 2) "Attachments". Table of Contents states that Proposal Outline is Section IV, so perhaps it is just mislabeled in the body of the agreement?

Response: Please see Addendum 1, A. Amendments to the original RFP issued on June 6, 2016. 3. The amendment to the original RFP in SECTION V PROPOSAL OUTLINE:

24. **Question**: In Section V. A. the MQISSP Quality Measure Set is outlined on both page 57 and page 58 but they are slightly different; which is accurate?

Response: The quality measure set on page 58 is the updated version. The version on page 57 is outdated and was included in error.

25. **Question**: If a provider organization is incorporated under a single tax ID that has sole contracting authority for its member providers, can the group representative sign the Group Agreement and submit the list of providers in Attachment C?

    Response: Yes, so long as the provider organization meets all applicable requirements in the RFP, including those requirements described on Pages 43-44 of the RFP.

26. **Question:** Is a single tax ID provider organization considered an Advanced Network Lead Entity or an Advanced Network if there are no other providers included in the Advanced Network (i.e., a group of 300+ providers, all of whom are employed by a professional corporation that operates under a single tax ID #. If we chose not to invite any providers from outside our group to participate in the Advanced Network, would our group's providers need to attach individual letters intent for each of its 300+ providers or would a single signature from the Chief Medical Officer and President/CEO be sufficient since the providers have delegated their contracting rights to our group?)

    Response: If the Advanced Network includes only one provider organization, then the Advanced Network is the same as the Advanced Network Lead Entity and there is no need to attach individual letters of intent for individual practitioners employed by the provider organization. A single letter of intent from such a provider organization, signed by any authorized signatory, will be sufficient.

27. **Question:** If a provider group is not required to be an Affirmative Action employer, how does that impact the group's eligibility to participate in MQISSP? It would make sense to have this be a requirement of FQHC's but private organizations that are not government contractors don't have the same requirement. The group would support the State's position for State employees.

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

    1. Equal Opportunity and Affirmative Action. The State is an Equal Opportunity and Affirmative Action employer and does not discriminate in its hiring, employment, or business practices. The State is committed to complying with the Americans with Disabilities Act of 1990 (ADA) and does

not discriminate on the basis of disability in admission to, access to, or operation of its programs, services, or activities.

Response: That statement refers to the fact that the State of Connecticut is an Equal Opportunity and Affirmative Action employer and does not impose any new requirements on respondents to the RFP.

28. Documentation of PCMH Status

    a. **Question:** Could you explain why the RFP calls for the Respondent to submit official communication from DSS documenting the participation of each of the providers in the DSS PCMH program? If the providers are already participating in the DSS PCMH program, wouldn't DSS already have that documentation on file? Or is DSS requesting something different?

       Response: The RFP requires that communication in order to facilitate expedited review of the RFP responses. DSS also plans to cross-check the providers against its internal documentation regarding PCMH practices.

    b. **Question:** With respect to providing "official communication from DSS" documenting the participation of each of the providers within the Advanced Network that are a PCMH practice in the PCMH program - is accessing and identifying such on the Connecticut Medical Assistance Program website sufficient.

       Response: The RFP respondent should provide a copy of the formal letter(s) that it received from DSS designating each PCMH practice as a participant in the DSS PCMH program. If the respondent cannot locate the formal letter(s), the respondent should contact DSS's Official Contact for assistance. In any case, DSS also plans to verify PCMH status based on its internal records.

    c. **Question:** How should we obtain documentation of our DSS PCMH status?

       Response: See response to Questions 28.b above.

29. **Question:** If DSS approves Respondent for participation in MQISSP, does the group need to commit to taking on a specific number of eligible beneficiaries (i.e., minimum/maximum)?

Response: No, so long as the group continues to maintain compliance with all MQISSP requirements, including the requirement that an MQISSP Participating Entity serve a minimum of 2,500 MQISSP eligible beneficiaries attributed to a PCMH.

30. **Question:** Is there any preference for an Advanced Entity including or not including pediatric Medicaid beneficiaries in its MQISSP group?

    Response: DSS does not have a preference as to the composition of the MQISSP members within an Advanced Network or FQHC. As referenced in the RFP, all members who are not in a category excluded from MQISSP, who are attributed to an Advanced Network or FQHC, and who do not opt out of MQISSP are counted as MQISSP members assigned to the Advanced Network or FQHC.

31. PCMH Certification Post-RFP Response

    a. **Question**: If PCMHs will have attained NCQA certification by September 2016, can their attributed beneficiaries count toward the 2500 minimum number of beneficiaries that an Advanced Entity must cover to be eligible to participate in MQISSP?

    Response: No, in order to be eligible to be considered for participation in MQISSP, at the time of submitting the RFP response the Advanced Network must have at least 2,500 MQISSP eligible beneficiaries attributed to one or more PCMH practices within the network (which must have achieved full PCMH status before submitting the RFP response). An Advanced Network can only receive shared savings payments based on MQISSP eligible beneficiaries who are attributed to a DSS PCMH practice within the network.

    Please note that in mid-2017, DSS expects to issue an RFP for a contract period starting January 1, 2018. This RFP will be open to Participating Entities that are selected to participate via this RFP, as well as new applicants that are at that time able to meet all requirements for MQISSP participation.

    Additional relevant information is included on page 43 of the RFP, which provides that in addition to meeting those minimum requirements, each Advanced Network must ensure that any non-PCMH primary care practices within the network must become a DSS PCMH practice within 18 months of the start of the first MQISSP Performance Year.

    b. **Question**: If PCMHs will have attained NCQA certification by September 2016, can those entities participate in shared savings in calendar year 2017 if

they remain certified throughout the year and participate in MQISSP throughout that calendar year?

Response: Yes, so long as the relevant FQHC or Advanced Network met the minimum requirements to be considered for participation in MQISSP (see response to Question 31.a immediately above). In order to be included in shared savings, full PCMH certification needs to be obtained before DSS runs the attribution that will be used to assign beneficiaries to the MQISSP Participating Entity for the following program year.

c. **Question**: If a PCMH is not certified at the start of an MQISSP program year but achieves certification during that year, are they eligible to (a) have their attributed beneficiaries count toward the network's covered beneficiaries and (b) participate in shared savings for the following calendar year if they remain certified throughout that following year and participate in MQISSP throughout that calendar year?

Response: If a PCMH is not certified at the start of an MQISSP program year, but achieves certification during that year, beneficiaries attributed to that practice are not counted as part of MQISSP shared savings for that program year—and included in the shared savings payment to the Advanced Network, if applicable.

However, if practice becomes certified as a PCMH before the attribution is performed that results in the assignment of MQISSP beneficiaries for the following program year, then so long as the Advanced Network met all applicable RFP requirements, those individuals will be counted as part of the MQISSP shared savings for the following program year.

32. **Documentation that Advanced Network Lead Entity is Authorized to Participate in MQISSP on Behalf of Advanced Network**

a. **Question:** On p. 15, the RFP says an Advanced Network must provide supporting documentation that it is authorized to participate in the RFP on behalf of their network members. What form of documentation will be considered appropriate: letters of commitment from other members, MOUs, MOAs, something else?

Response: The Advanced Network should submit what it considers to be appropriate documentation to show that it is authorized to participate on behalf of the network's member provider organizations based on its structure. DSS is not specifying the specific type of documentation so long as it is clear from the documentation that the Advanced Network Lead Entity is authorized to submit the RFP response (and participate in MQISSP, if selected) on

behalf of the Advanced Network. Separate documentation is not required from individual practitioners within an Advanced Network.

b. **Question:** What documentation is considered appropriate to demonstrate that the Advanced Network Lead Entity is authorized to participate in the RFP on behalf of the Advanced Network?

Response: See response to Question 32.a immediately above.

33. **Question:** For "engagement with local community partners", what documentation will be required to show "informal" partnerships?

    Response: The RFP does not specifically require respondent to provide documentation of formal or informal partnerships with community partners (see Pages 45, 52, and 53). However, submitting documentation of both formal and informal relationships may be helpful as part of the respondent's RFP submission. A letter from each community partner describing its partnership with the respondent will be an effective means of documenting the partnership.

34. **Question:** If a network is funded in 2017, what will it have to do to get continued funding from year to year?

    Response: Please note that DSS expects to issue an RFP for a contract period starting January 1, 2018. This RFP will be open to Participating Entities that are selected to participate via this RFP, as well as new applicants.

35. **Question:** For how many years is CT DSS expected to run the MQISSP program and issue new solicitations? On what factors does that decision depend?

    Response: Please note that DSS expects to issue an RFP for a contract period starting January 1, 2018. This RFP will be open to Participating Entities that are selected to participate via this RFP, as well as new applicants.

36. **Question:** If an Advanced Network is accepted into the program for 2017, for how many years might it expect to participate? Based on what factors might CT DSS allow an Advanced Network to continue to participate in the program?

Response: This RFP is solely for MQISSP program year 2017 (for dates of service in calendar year 2017).
Please note that DSS expects to issue an RFP for a contract period starting January 1, 2018. This RFP will be open to Participating Entities that are selected to participate via this RFP, as well as new applicants.

37. **Question:** If attributed beneficiaries select a different MQISSP Advanced Network for their health care during a year but choose their old network in the following year, are they counted toward the newly chosen network's total number of beneficiaries in the following year? Do they count toward the shared savings calculations for network in the year in which they rejoin their old network?

    Response: As described in the RFP, members will be prospectively assigned to an MQISSP Participating Entity based on the attribution calculation made at the time of assignment. That methodology drives the assignment, and will yield the resulting assignment.

    DSS suggests that all MQISSP Participating Entities (both FQHCs and Advanced Networks) focus on providing high quality, person-centered, service to MQISSP beneficiaries. Improving customer service in general, as well as ensuring uniformly high quality services, will encourage members remain with the MQISSP Participating Entity.

38. **Question:**
    a. Can an Advanced Network alter its composition of participating health care entities or community partnerships once selected for MQISSP? If so, can it only be done for the start of a new calendar year? Or at some other interval? What would they have to do to accomplish such a change?

    Response: Yes, an Advanced Network can alter its composition of participating health care entities and/or community partnerships at any time, so long as the Advanced Network continues to meet all MQISSP requirements. The Advanced Network will be required to inform DSS in writing of any such changes and update appropriate documentation accordingly.

    b. **Question:** Is a health care participant in a network obliged to remain with the network through the end of a calendar year? Are there circumstances under which they could leave a network during a calendar year?

    Response: No, a health care participant in a network is not obliged to remain with the network through the end of the calendar year and could leave at any

time. However, see response to Question 38.a immediately above for potential consequences if the departure of a participant in the network means that the Advanced Network no longer meets all MQISSP program requirements. Specifically, the departure of a PCMH from an Advanced Network will result in removal of its assigned beneficiaries for purposes of calculating any applicable shared savings payment.

c. **Question:** If an Advanced Network Lead Entity or other participating health care organization experienced a structural administrative change during 2017 or during a subsequent MQISSP funding year, how might that affect continuing participation in MQISSP for that funding year or subsequent years?

Response: See responses to Questions 38.a and 38.b immediately above.

39. **Question:** If an Advanced Network Lead Entity is a health system that owns a variety of health care delivery entities, are all such entities *required* to participate in the Advanced Network even if some are not eligible to seek NCQA PCMH certification or if some are not able to seek such status based on the current level of their care practice (e.g., those not likely meet certification standards within 18 months)?

    Response: No, all such entities are not required to participate in the Advanced Network. The RFP acknowledges that a variety of non-primary care provider types can participate in the Advanced Network, such as specialist(s) and/or hospital(s) or a Medicare Accountable Care Organization (ACO). Those non-primary care provider entities are not be eligible to participate in the DSS PCMH program but may participate as part of the Advanced Network.

    The Advanced Network can choose how to characterize itself and could potentially include a subset of a health system, rather than the entire health system, so long as the Advanced Network can clearly describe and document how it is comprised and structured. A health system also clearly has a substantial amount of flexibility in how it is structured generally, including which providers are included within which entities. Regardless of the composition and manner in which the Advanced Network presents for purposes of its RFP response, any non-PCMH primary care practices that are within the Advanced Network must achieve PCMH status within the time frame that is detailed on Page 43 of the RFP.

40. **Question:** If CT DSS were to implement other demonstration projects that had payment implications during 2017 or in a subsequent MQISSP funding

year, how might those programs be integrated into MQISSP? For example, if you piloted a demonstration project providing a bundled payment for a condition or defined Medicaid population, how might that affect the rules for MQISSP participation, MQISSP evaluation measures and/or shared savings calculations?

Response: DSS will align any potential future initiatives with MQISSP.

41. **Question:** What is the rationale for requiring that individual practitioners not be [individually] rewarded for contributions to the network's shared savings?

    Response: The rationale for this requirement is to minimize any potential incentives for individual practitioners to cause or promote under-service. This includes removing any direct incentive that might potentially encourage a practitioner to avoid referring a patient for medically necessary tests or procedures that would potentially increase expenditures substantially.

    With the exception of that exclusion, MQISSP Participating Entities will have a substantial amount of discretion and flexibility in designing their distribution methodology for shared savings payments. For example, a network could choose to distribute shared savings payments based on a practitioner's quality of performance, patient satisfaction, and/or other metrics. These factors should be captured in each respondent's description of its proposed shared savings methodology.

42. **Question:** In addition to the Cover Sheet, are there any other documents that require "original signatures" to be compliant with CT DSS submission requirements?

    Response: All signatures in the Original Proposal shall be original signatures.

43. **Question:** What is the significance of p. 57 of Attachment A vs. p. 58? It appears that p. 57 is simply an earlier iteration. Is that correct?

    Response: Yes, page 57 is an outdated version that was included in error. Page 58 is the correct version of the quality measures.

44. **Question:** Does an Advanced Network Lead Entity have to be a separately incorporated entity or can it be a subsidiary of an existing entity provided it meets all the requirements of DSS?

Response: The Advanced Network Lead Entity may be a subsidiary of an existing entity so long as it meets all applicable MQISSP requirements, including, but not limited to, the requirement that it be authorized to act on behalf of the entity of which it is a part and be authorized to act on behalf of the Advanced Network. In very practical terms, the Advanced Network Lead Entity must be able to enter into a contract with DSS, regardless of how that entity is structured.

45. **Question:** Does the Advanced Network have to meet all the requirements under the definitions Under Section I General Information, #2 (1-4) page 7 or one of the listed items.

    Response: The Advanced Network must meet one of the listed items within the definition of an Advanced Network on Page 7.

46. **Question:** Section C ("Instructions") #4 ("Eligibility") states that "an organization must be an enrolled Connecticut Medicaid provider and meet the additional minimum qualifications of an FQHC or an Advanced Network as specified in Section III.F.1." Does an Advanced Network Lead Entity meet the eligibility requirements if it has a participating provider or several as part of its participating provider network, or does the Advanced Network Entity Lead have to be a separately licensed, participating DSS provider.

    Response: As described in the definition of an Advanced Network Lead Entity on Page 7, the Advanced Network Lead Entity may be a provider organization entity, and not necessarily an individual provider. Thus, an Advanced Network Lead Entity could include participating provider(s) as part of its participating provider network.

47. **Question:** Please define the term "substantial" representation of MQISSP members on the oversight body referenced in item Section I General Information, D.6 Executive Summary b.iii.

    Response: This term is intentionally not defined in order to give MQISSP Participating Entities the flexibility to design the oversight body to meet the unique circumstances of that entity and its constituent provider(s). The respondent should describe its proposed composition and should explain how it includes substantial and meaningful representation of MQISSP members.

48. **Question:** When does DSS intend to establish the criteria for identifying systemic under-service and panel manipulation?

Response: See response to Question 9 within Addendum 1.

49.
a. **Question:** How will DSS determine the "comparison groups" on which they'll base the shared savings calculation?

   Response: Comparison groups will be determined based on similarly situated DSS PCMH practices that either do not apply to participate in, or are not selected to participate in, MQISSP.

b. **Question:** What is the definition and parameters of a comparison group for purposes of the quality and cost benchmark, referenced on page 35, section 7 of the Shared Savings Payment Methodology.

   Response: See response to Question 50.a immediately above.

50. **Question:** When will DSS provide a definition of the reporting requirements referenced in Section III, number 8 Monitoring and Oversight.

    Response: DSS expects to issue detail on reporting requirements on or before December 31, 2016. DSS welcomes respondents to offer recommendations within their RFP responses on reporting requirements.

51. **Question:** Can DSS specify which individuals participating in the MQISSP program would be considered "key personnel" and therefore subject to the contract requirements?

    Response: This "key personnel" provision is a standard component of all RFP documents, but does not apply to MQISSP Participating Entities.

52. **Question:** Can you confirm that there will be two waves of the MQISSP opportunity, and, if so, what the anticipated timing of the second wave will be?

    Response: Please note that DSS expects to issue an RFP for a contract period starting January 1, 2018. This RFP will be open to Participating Entities that are selected to participate via this RFP, as well as new applicants.

53. **Question:** Can FQHCs subcontract to another provider for some or all of the Care Coordination Add-On Payment Activities for some or all of the MQISSP Members?

    Response: No, the MQISSP Participating Entity must provide required care coordination through individuals directly employed by, under contract to, or otherwise affiliated with the MQISSP Participating Entity. The purpose of this requirement is to ensure that care coordination is an essential part of the services provided by the MQISSP Participating Entity and is fully integrated into the day-to-day work of the overall entity.

58. **Question**: Do we qualify as an Advanced Network/Advanced Network Lead Entity for the shared savings RFP that was recently released? As a Multi-Specialty Group, we have 8 PCPs who are PCMH recognized, and they work under the same umbrella/policies with many specialists (including behavioral health). Also, the definition of an Advanced Network talks about "Enhanced Care Coordination Activities," which I'm presuming is not the same as being an ECC, though wondering if the expectation is that the same measures that ECCS adhere to are being met.

    Response: A specialty group that includes PCPs who are affiliated with DSS PCMH practices can meet the definition of an Advanced Network / Advanced Network Lead Entity for purposes of MQISSP. Eligibility for MQISSP also depends on whether the entity has at least 2,500 attributed Medicaid members who are also eligible for MQISSP (i.e., not in one of the excluded categories of members). If a practice has 8 PCPs in a PCMH and is not in a network with any other PCMH practices, that practice should be very careful to determine whether or not it meets the minimum 2,500 attributed MQISSP members who are eligible for MQISSP. Enhanced care coordination activities are detailed in the RFP on Pages 45-47. These are not the same as requirements for Enhanced Care Clinics.

Addendum 1

Medicaid Quality Improvement and Shared Savings Program
Participating Entities Request for Proposals
MQISSP_RFP_060616

Date Issued: June 30, 2016

Approved: _____
Marcia McDonough

State of Connecticut Department of Social Services
(Original signature on document in procurement file)

This Addendum must be signed and returned with your submission.

_____	_____
Authorized Signer	Name of Company

State of Connecticut Department of Social Services

PROCUREMENT NOTICE

Medicaid Quality Improvement and Shared Savings Program (MQISSP)
Participating Entities Request for Proposals (RFP)

The State of Connecticut Department of Social Services (Department or DSS) is requesting proposals from qualified Federally Qualified Health Centers and Federally Qualified Health Center Look-Alikes (collectively, FQHCs) and Advanced Network Lead Entities (on behalf of Advanced Networks) to become Participating Entities in the Department's new Medicaid Quality Improvement and Shared Savings Program (MQISSP). MQISSP aims to improve health outcomes and the care experience of Medicaid beneficiaries and to contain the growth of health care costs. Selected FQHCs and Advanced Networks will provide care coordination activities to improve the quality, efficiency, and effectiveness of care delivered to Medicaid beneficiaries.

If an MQISSP Participating Entity meets specified quality performance standards, including measures of under-service, and generates savings for the Connecticut Medicaid program, then that MQISSP Participating Entity will receive a payment calculated using a shared savings methodology (described in Section III.E.7 of this request for proposal (RFP)). In addition, MQISSP Participating Entities that are FQHCs will receive a Care Coordination Add-On Payment paid prospectively on a monthly basis for Care Coordination Add-On Payment Activities that the FQHC will provide to MQISSP Members. There will be no downside risk (i.e., MQISSP Participating Entities will not return any share of increased expenditures incurred by Connecticut Medicaid).

Minimum Qualifications of Respondents. To be considered eligible to respond to this RFP, an organization must be an enrolled Connecticut Medicaid provider, and meet the additional minimum qualifications of an FQHC or an Advanced Network as specified in Section III.F.1 of this RFP.

Individuals who are not a duly formed business entity that is incorporated in or registered to do business in the State of Connecticut are ineligible to participate in this procurement. The Department reserves the right to reject the submission of any Respondent in default of any current or prior contract.

General Procurement Information. An RFP Conference will be held on June 13, 2016.

Interested Respondents must submit a Letter of Intent to the Department no later than 2:00 pm Eastern Time on July 12, 2016.

<u>The deadline for submission of proposals is July 26, 2016, 2:00 pm Eastern Time.</u>

Proposals received after the stated due date and time may be accepted by the Department as a clerical function, but will not be evaluated. Those proposals that are not

evaluated can be picked up by the Respondent after notification from the Official Contact or will be retained for thirty (30) days after the resultant contracts are executed, after which time the proposals will be destroyed.

The RFP is available in electronic format on the State Contracting Portal at http://das.ct.gov/cr1.aspx?page=12 or from the Department's Official Contact:

Name:	Marcia McDonough, Contract Administration and Procurement
Address:	State of Connecticut, Department of Social Services 55 Farmington Ave. 2nd Floor, Hartford, CT 06105-3730
Phone:	(860) 424-5214
Fax:	(860) 424-5800
Email:	Marcia.McDonough@ct.gov

The RFP is also available on the Department's website at: http://www.ct.gov/dss/rfp

Questions or requests for information in alternative formats must be directed to the Department's Official Contact. Persons who are deaf or hearing impaired may use a TDD by calling 1-800-842-4524.

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I. GENERAL INFORMATION

A. INTRODUCTION

1. **Request for Proposal Name.** Medicaid Quality Improvement and Shared Savings Program Participating Entities Request for Proposals (MQISSP_RFP)

2. **Summary.** The State of Connecticut Department of Social Services (Department or DSS) seeks to contract with Federally Qualified Health Centers and Federally Qualified Health Center Look-Alikes (collectively, FQHCs) and Advanced Network Lead Entities (on behalf of Advanced Networks) to become MQISSP Participating Entities. The goal of MQISSP is to improve quality and the care experience of Medicaid beneficiaries.

   The Department is implementing MQISSP as part of Connecticut's State Innovation Model (SIM) Model Test grant. The Department recognizes that Medicaid payment reform, moving from volume-based to value-based provider payments, is essential to support flexibility in engaging and supporting beneficiaries in meeting their health needs. Moreover, Medicaid's participation in payment reform, along with other payers, will help change the focus of the State of Connecticut's health care system from volume-based to value-based models of care delivery and payment. Because SIM is focused on innovation, respondents to this RFP are encouraged to be innovative in how they explain how they plan to meet the requirements of this RFP, including incorporating their own insights, experience, and creativity in the shared goals of improving Connecticut's Medicaid program.

   MQISSP is guided by a number of important values:

   - Protecting the interests of Medicaid beneficiaries;
   - Building on the platform of the Department's Person-Centered Medical Home (PCMH) program (link to DSS PCMH program), as well as the strengths and analytic capability of the Medicaid program's medical Administrative Services Organization (ASO);
   - Enhancing capacity at practices where Medicaid beneficiaries are seeking care to improve health outcomes and care experience; and
   - Encouraging the use of effective care coordination to address the social determinants of health.

   Through MQISSP, FQHCs and Advanced Networks will provide Enhanced Care Coordination Activities to MQISSP Members. FQHCs will also provide Care Coordination Add-On Payment Activities. All Connecticut Medicaid beneficiaries will be eligible for assignment to MQISSP Participating Entities, with the exception of populations who already receive extensive care coordination via other state and federal programs, or who have another source of health care coverage or a limited Medicaid benefit (see Section III.E.1). The Department's goal is to assign approximately 200,000 to 215,000 Medicaid beneficiaries to MQISSP Participating Entities selected through this procurement.

   If an MQISSP Participating Entity generates savings for the Connecticut Medicaid program and also meets specified quality performance standards, including measures of under-service, the entity will share in the savings achieved. In addition, MQISSP

Participating Entities that are FQHCs will receive a Care Coordination Add-On Payment paid prospectively on a monthly basis for Care Coordination Add-On Payment Activities that the FQHCs will be required to provide to MQISSP Members. There will be no downside risk for MQISSP Participating Entities, meaning that MQISSP Participating Entities will not be required to return any portion of increased expenditures incurred by Connecticut Medicaid. Additional information regarding payments under MQISSP can be found in Sections III.E.4, III.E.5, and III.E.6 of this RFP.

Contracts for MQISSP Participating Entities selected through this procurement are expected to begin on January 1, 2017. At that time, FQHCs and Advanced Networks will begin providing Enhanced Care Coordination Activities as defined in Section III.F.3, MQISSP Participating Entities that are FQHCs will begin providing Care Coordination Add-On Payment Activities, and the Department will begin making Care Coordination Add-On Payments to MQISSP Participating Entities that are FQHCs (described in Section III.F.4).

3. **Readiness Assessment.** The Department reserves the right to perform a readiness assessment of any current or prospective MQISSP Participating Entity or to require such entity to arrange to perform a readiness assessment as specified by the Department. The Department may provide technical assistance as it deems necessary to help enable a current or prospective MQISSP Participating Entity to participate effectively in MQISSP.

4. **Commodity Codes.** The services that the Department wishes to procure through this RFP are as follows:

   - 0098: Medical Services or Medical Testing Services
   - 1000: Healthcare Services
   - 2000: Community and Social Services

■ B. ABBREVIATIONS/ACRONYMS/DEFINITIONS

1. Abbreviations/Acronyms

ACO	Accountable Care Organization
ADA	Americans with Disabilities Act of 1990
ASO	Administrative Services Organization
BFO	Best and Final Offer
C.G.S.	Connecticut General Statutes
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCIP	Community and Clinical Integration Program
CHRO	Commission on Human Rights and Opportunities (CT)
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare & Medicaid Services (U.S.)
CMM	Comprehensive Medication Management
CMMI	Center for Medicare & Medicaid Innovation (U.S.)
CT	State of Connecticut
CYSHCN	Children and Youth with Special Health Care Needs
Department	State of Connecticut Department of Social Services
DAS	Department of Administrative Services (CT)
DME	Durable Medical Equipment

DSS	State of Connecticut Department of Social Services
FOIA	Freedom of Information Act (CT)
FQHC	Federally Qualified Health Center or Federally Qualified Health Center Look-Alike
HEDIS	Healthcare Effectiveness Data and Information Set
HRSA	Health Resources and Services Administration (U.S.)
LOI	Letter of Intent
LTSS	Long-term Services and Supports
MMIS	Medicaid Management Information System
MQISSP	Medicaid Quality Improvement and Shared Savings Program
NCQA	National Committee for Quality Assurance
OAG	Office of the Attorney General (CT)
OPM	Office of Policy and Management (CT)
PCMH	Person-Centered Medical Home
PHSA	Public Health Service Act
PMO	Project Management Office
POS	Purchase of Service
RFP	Request for Proposals
SEEC	State Elections Enforcement Commission (CT)
SHIP	State Healthcare Innovation Plan
SIM	State Innovation Model
State	State of Connecticut
TAY	Transition Age Youth
U.S.	United States
WRAP	Wellness Recovery Action Plan

2. Definitions

Advanced Network	A provider organization or group of provider organizations that provide Enhanced Care Coordination Activities to MQISSP Members. At a minimum, an Advanced Network must include a practice currently participating in DSS' PCMH program (other than a Glide Path practice). Acceptable options for Advanced Network composition include: 1. One or more DSS PCMH practice(s); 2. One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health and oral health providers; 3. One or more DSS PCMH practice(s) plus specialist(s) (which could include physical health, behavioral health and oral health providers) and one or more hospital(s); or 4. A Medicare Accountable Care Organization (ACO) that includes one or more DSS PCMH practice(s). Please Note: This definition is unique to MQISSP and differs from the general Connecticut SIM definition of Advanced Network. For purposes of MQISSP, the Advanced Network must meet the definition described above but, unlike the general SIM definition, is not required to have risk-bearing contracts for providing health services.
Advanced Network Lead Entity	A provider or provider organization that contracts with the Department on behalf of the Advanced Network and fulfills the functions specified in Section III.F.1.a. The Advanced Network Lead Entity must be a participating provider in the Advanced Network.
Care Coordination Add-On Payment	Payments paid prospectively on a monthly basis to MQISSP Participating Entities that are FQHCs for providing Care Coordination Add-On Payment Activities to MQISSP Members.
Care Coordination Add-On Payment Activities	Care coordination activities that MQISSP Participating Entities that are FQHCs will be required to provide to MQISSP Members in order to receive the Care Coordination Add-On Payment. The Care Coordination Add-On Payment Activities are in addition to the Enhanced Care Coordination Activities required of all MQISSP Participating Entities.

Community and Clinical Integration Program	The Community and Clinical Integration Program (CCIP) is comprised of a set of care delivery standards and technical assistance that is intended to enable Advanced Networks and FQHCs to deliver care that results in better health outcomes at lower costs for Medicare, Medicaid, and commercial plan enrollees. CCIP participants will receive free technical assistance, as well as peer support through a learning collaborative.
Comparison Group	The comparison group is the group of health providers that participate in Connecticut's Medicaid program as PCMH practices but are not MQISSP Participating Entities and, to the extent possible, will be chosen to resemble the MQISSP Participating Entities in size, location, attributed members' demographics and risk scores, and other factors that would likely influence provider performance. Because it is not yet known which providers will become MQISSP Participating Entities, it is not possible to determine the specific comparison group in advance. The comparison group will be used as part of determining the MQISSP shared savings calculation, as explained in this RFP.
Contractor	See MQISSP Participating Entity.
Contract	The Contract awarded to the successful Respondents pursuant to this RFP.
Day	Calendar day.
Enhanced Care Coordination Activities	Required care coordination activities that all MQISSP Participating Entities must provide. These activities are described in Section III.F.3 of this RFP.
Federally Qualified Health Center	An entity that meets the definition of an FQHC in section 1905(l)(2)(B) of the Social Security Act and meet all requirements of the HRSA Health Center Program, including both organizations receiving grants under Section 330 of the Public Health Service Act and also FQHC Look-Alikes, which are organizations that meet all of the requirements of an FQHC but do not receive funding from the HRSA Health Center Program.
MQISSP Member	Medicaid beneficiaries prospectively assigned to MQISSP Participating Entities using the Department's PCMH retrospective attribution process, which has been adapted for MQISSP.

MQISSP Participating Entity	An FQHC or Advanced Network (represented by the Advanced Network Lead Entity) contracted by the Department to participate in MQISSP. Also referred to as Contractor.
MQISSP Quality Measures	The set of quality measures used to evaluate the performance of MQISSP Participating Entities and the performance of the MQISSP as a whole. Specific quality measures may be for reporting purposes only, or may be utilized to calculate an MQISSP Participating Entity's quality performance as part of the shared savings calculations. The current version of the MQISSP quality measure set can be found in Attachment A of this RFP.
Performance Year or Performance Period	The time period in which MQISSP Participating Entities will provide Enhanced Care Coordination Activities and improve the quality of care. This is also the time period that the performance of the MQISSP Participating Entities will be evaluated for the purpose of the shared savings calculation.
Prior Year	The time period preceding the Performance Year for purposes of establishing the MQISSP Participating Entities' and comparison group's cost baseline and quality measure benchmarks.
Prospective Respondent	A provider organization that may submit a proposal to the Department in response to this RFP, but has not yet done so.
Official Contact	The DSS staff person who serves as Respondents' sole point of contact regarding this RFP. The Official Contact for this RFP is Marcia McDonough.
Respondent	A provider organization (FQHC or Advanced Network Lead Entity on behalf of an Advanced Network) that has submitted a proposal to the Department in response to this RFP.
Subcontractor	An individual (other than an employee of the Contractor) or business entity hired by a Contractor to provide a specific service as part of a Contract with the Department as a result of this RFP.

State Innovation Model	An initiative created by the Center for Medicare & Medicaid Innovation (CMMI) to provide financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that is designed to improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program beneficiaries — and for all residents of participating states. For additional information, see http://innovation.cms.gov/initiatives/state-innovations/.
Transition Age Youth	Commonly defined as individuals between the ages of 16 and 25 years. The age range for transition age youth (TAY) can vary to include children as young as 12 years of age.

■ C. INSTRUCTIONS

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

   Name: Marcia McDonough, Contract Administration and Procurement
   Address: State of Connecticut, Department of Social Services
   55 Farmington Ave. 2nd Floor, Hartford, CT 06105-3730
   Phone: (860) 424-5214
   Email: Marcia.McDonough@ct.gov

   Please ensure that email-screening software (if used) recognizes and accepts emails from the Official Contact.

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

   - Department's RFP Web Page: http://www.ct.gov/dss/rfp
   - State Contracting Portal: http://das.ct.gov/cr1.aspx?page=12

   It is strongly recommended that any Respondent or Prospective Respondent interested in this procurement subscribe to receive email alerts from the State Contracting Portal. Subscribers will receive a daily email announcing procurements and addenda that are posted on the portal. This service is provided as a courtesy to assist in monitoring

activities associated with State of Connecticut procurements, including this RFP. Printed copies of all documents are also available from the Official Contact upon request.

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

Total Funding Available:	$4,500,000 for one MQISSP program year, which represents the state share of the Care Coordination Add-On Payments to FQHCs. This amount does not include the federal share of those payments, nor does it include the state or federal share of any shared savings payments.
Number of Contracts:	Up to the total number of qualifying FQHCs and Advanced Networks. The Department will not limit the number of qualifying respondents from being selected as MQISSP Participating Entities.
Contract Cost:	To be determined in accordance with the methodology for shared savings payments and care coordination add-on payments, if applicable, as described elsewhere in this RFP.
Contract Term:	One (1) year period.

4. **Eligibility.** To be considered eligible to respond to this RFP, an organization must be an enrolled Connecticut Medicaid provider and meet the additional minimum qualifications of an FQHC or an Advanced Network as specified in Section III.F.1. of this RFP, as applicable.

   Individuals who are not a duly formed entity that is incorporated in or registered to do business in Connecticut are ineligible to participate in this procurement. The Department reserves the right to reject the submission of any Respondent in default of any current or prior contract.

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

   - RFP Released: June 6, 2016
   - RFP Conference: June 13, 2016
   - Deadline for Questions: June 20, 2016, 2:00 pm Eastern Time
   - Answers Released (tentative): June 30, 2016
   - Letter of Intent (LOI) Due: July 12, 2016, 2:00 pm Eastern Time
   - Proposals Due: July 26, 2016, 2:00 pm Eastern Time
   - Start of Contract*: January 1, 2017

6. **Letter of Intent.** A LOI **is required** by this RFP. The LOI is non-binding and does not obligate the sender to submit a proposal. The LOI must be submitted to the Official Contact by United States (U.S.) mail, fax, or email by the deadline established in the Procurement Schedule. The LOI must clearly identify the sender, including name, mailing address, telephone number, fax number, and email address. It is the sender's responsibility to confirm the Department's receipt of the LOI. Failure to submit the

required LOI in accordance with the requirements set forth herein shall result in disqualification from further consideration.

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

8. **RFP Conference.** An RFP conference will be held to answer questions from Prospective Respondents. Attendance at the conference is strongly encouraged. Copies of the RFP will not be available at the RFP Conference. Prospective Respondents are asked to bring a copy of the RFP to the conference. At the conference, attendees will be provided an opportunity to submit written questions, which the Department's representatives may (or may not) answer at the conference. Any oral answers given at the conference by the Department's representatives are tentative and not binding on the Department. All questions submitted will be answered in a written addendum to this RFP, which will serve as the Department's official response to questions asked at the conference. If any answer to any question constitutes a material change to the RFP, the question and answer will be placed at the beginning of the addendum and duly noted as such. The agency will release the addendum on the date established in the Procurement Schedule. The Department will publish any and all amendments and addenda to this RFP on the State Contracting Portal and on the Department's RFP Web Page.

   Limited visitor parking is located directly across from DSS Central Office. Due to limited parking, please plan to arrive early to allow extra time for parking. Please proceed to the security desk, upon arrival.

   - Date: June 13, 2016
   - Time: 9:00 to 11:00 a.m.
   - Location: DSS Central Office, 55 Farmington Avenue, Hartford, CT 06105

9. **Proposal Due Date and Time.** The Official Contact or designee of the Official Contact is the <u>only authorized recipient</u> of proposals submitted in response to this RFP. Proposals shall be received by the Official Contact on or before the due date and time:

- Due Date: July 26, 2016
- Time: 2:00 pm Local Time

Faxed proposals will not be evaluated. The Department shall not accept a postmark date as the basis for meeting the proposal due date and time. Respondents should not interpret or otherwise construe receipt of a proposal after the due date and time as acceptance of the proposal, since the actual receipt of the proposal is a clerical function. The Department suggests the Respondent use certified or registered mail, or a delivery service such as United Parcel Service (UPS) to deliver the proposal. When hand-delivering proposals, Respondents should allow extra time to comply with building security and delivery procedures. Limited visitor parking is located directly across the street from DSS Central Office, 55 Farmington Avenue, Hartford, Connecticut. Due to limited visitor parking, please allow extra time for parking.

Hand-delivered proposals shall be delivered to the security desk located in the lobby of the building, at 55 Farmington Avenue. The Official Contact or designee of the Official Contact will receive the proposal and provide the Respondent or courier with a receipt.

Proposals shall not be considered received by the Department until they are in the hands of the Official Contact or another representative of the Contract Administration and Procurement Unit designated by the Official Contact. At the discretion of the Department, late proposals may be destroyed or retained for pick-up by the Respondents.

An acceptable submission must include the following:

- One (1) original submission;
- Five (5) conforming copies of the original submission; and
- Two (2) conforming electronic copies (Compact Disk) of the original submission. Flash drives are not acceptable.

The original submission shall carry original signatures and be clearly marked on the cover as “Original.” Unsigned submissions will not be evaluated. The original submission and each conforming copy of the submission shall be complete, properly formatted and outlined, and ready for evaluation by the Evaluation Team. **The electronic copies of the submission shall be compatible with Microsoft Office Word.** For the electronic copy, only the required appendices and forms may be scanned and submitted in Portable Document Format (PDF) or similar file format. Flash drives are not acceptable.

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

■ D. PROPOSAL FORMAT

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

2. **Cover Sheet.** The Cover Sheet is Page 1 of the proposal. Respondents must complete and use the Cover Sheet form, which is embedded in this section as a hyperlink.

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

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

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

5. **Conflict of Interest - Disclosure Statement.** Respondents must include a disclosure statement concerning any current business relationships (within the past three (3) years) that pose a conflict of interest, as defined by C.G.S. § 1-85. A conflict of interest exists when a relationship exists between the Respondent and a public official (including an elected official) or State of Connecticut employee that may interfere with fair competition or may be adverse to the interests of the State. The existence of a conflict of interest is not, in and of itself, evidence of wrongdoing. A conflict of interest may, however, become a legal matter if a Respondent tries to influence, or succeeds in influencing, the outcome of an official decision for their personal or corporate benefit. The Department will determine whether any disclosed conflict of interest poses a substantial advantage to the Respondent over the competition, decreases the overall competitiveness of this procurement, or is not in the best interests of the State. In the absence of any conflict of interest, a Respondent must affirm such in the disclosure statement*: "[name of Respondent] has no current business relationship (within the past three (3) years) that poses a conflict of interest, as defined by C.G.S. § 1-85."*

6. **Executive Summary.** Proposals must include a high-level summary, not exceeding three (3) pages, of the main proposal. This component of the proposal should demonstrate the Respondent's understanding of the requirements in this RFP and show how the Respondent will meet these requirements. The Executive Summary should also describe any problems anticipated in meeting these requirements and how the Respondent will address these anticipated problems.

   a. Supporting Documentation – Provide the documentation applicable to your organization, as attachments to the Executive Summary, labeled ***Supporting Documentation***. Supporting Documentation is not included in the three (3) page limitation of the Executive Summary.

      i. Provide supporting documentation regarding the Respondent's qualifications to participate in MQISSP as an FQHC or an Advanced Network Lead Entity.
         (1) For FQHCs, either: (a) provide documentation that reflects receipt of HRSA grant funding under Section 330 of the PHSA or (b) for FQHC Look-Alikes, provide documentation that HRSA has designated the entity as an FQHC Look-Alike.
         (2) For FQHCs, provide official communication from DSS documenting the participation of the FQHC as a participant in the DSS PCMH program.
         (3) For FQHCs, provide documentation that reflects receipt of Level 2 or Level 3 Patient-Centered Medical Home recognition from NCQA or Primary Care Medical Home certification from The Joint Commission.
         (4) For Advanced Network Lead Entities, provide official communication from DSS documenting the participation of each of the providers within the Advanced Network that are a PCMH practice in the DSS PCMH program. (At least one provider in the Advanced Network must currently participate as a PCMH in the DSS PCMH program.)
         (5) For Advanced Network Lead Entities submitting proposals for Advanced Networks that are ACOs as that term is defined in the Medicare Shared Savings Program, provide a copy of the official communication from CMS documenting the Respondent's participation as an ACO in the Medicare Shared Savings Program.
         (6) For Advanced Network Lead Entities, a description and accompanying supporting documentation to show that the Advanced Network Lead Entity is authorized to participate in this RFP on behalf of the Advanced Network, is authorized to enter into a potential contract as an MQISSP Participating Entity on behalf of the Advanced Network, and has the ability to ensure that the Advanced Network complies with all applicable requirements, including, but not limited to all of the MQISSP Participating Entity provider qualifications for Advanced Networks.

   b. To qualify for participation in MQISSP, each MQISSP Participating Entity is required to provide statements acknowledging that its organization adheres to the requirements listed below. Provide the Acknowledgement Statements as Attachments to the Executive Summary, labeled ***Acknowledgment Statements.*** The statements are not included in the three (3) page limitation of the Executive Summary.

      i. At the time of submitting the response to this RFP, have at least 2,500 DSS PCMH Program attributed beneficiaries who are eligible to participate in MQISSP. If the respondent needs information or data about its attributed

beneficiaries, the respondent may ask the Department's Official Contact in writing;

ii. Ensure that only providers enrolled in Connecticut Medicaid are providing Medicaid services to MQISSP Members (link to Connecticut Medical Assistance Program Provider Enrollment website); and

iii. Have an oversight body that may, but is not required to, overlap with an existing governing board or an existing advisory body. The oversight body must include substantial representation by MQISSP Members assigned to the MQISSP Participating Entity and at least one provider participating in the MQISSP Participating Entity. The type and number of providers on the oversight body need not be proportional to MQISSP Participating Entity participating providers, but must be representative of the variety of providers participating in the MQISSP Participating Entity (e.g., primary care, other physical health providers, behavioral health providers, oral health providers, etc.). The oversight body must:
   a. Meet at least quarterly and provide meaningful feedback to the MQISSP Participating Entity on a variety of topics, including quality improvement, member experience, prevention of underservice, implementation of MQISSP, and distribution of shared savings.
   b. Have a transparent governing process;
   c. Have bylaws that reflect the oversight body's structure as well as define its ability to support the MQISSP objectives;
   d. Have a conflict of interest policy calling for disclosure of relevant financial interests and a procedure to determine whether conflicts exist and an appropriate process to resolve conflicts.

c. Advanced Networks must, at a minimum, provide a Confirmation that the Advanced Network complies with the two requirements listed below. Provide the Confirmation as an attachment to the Executive Summary, labeled ***Advanced Network Confirmation***. The Confirmation is not included in the three (3) page limitation of the Executive Summary.

i. Include one or more practice(s), identified by name(s) and national provider identifier(s), that is/are currently participating in the DSS PCMH program and hold/holds Level 2 or 3 Patient-Centered Medical Home recognition from NCQA. Practices with Glide Path designation, which is a step towards DSS PCMH recognition, do not count as meeting this requirement.

ii. Require any non-DSS PCMH primary care practices within the Advanced Network to become DSS PCMH program participants within eighteen (18) months of the start of the first MQISSP Performance Year.

d. FQHCs must, at a minimum, confirm the following. Provide the Confirmation as an attachment to the Executive Summary, labeled ***FQHC Confirmation***. The Confirmation is not included in the three (3) page limitation of the Executive Summary.

ii. Meet all requirements of an FQHC under section 1905(l)(2)(B) of the Social Security Act,

iii. Have either: (A) HRSA grant funding as an FQHC under Section 330 of the PHSA or (B) HRSA designation as an FQHC Look-Alike,

iv. Operate in Connecticut and meet all federal and state requirements applicable to FQHCs;

v. Be a current participant in the DSS PCMH program (Glide Path practices are excluded) and hold current Level 2 or 3 Patient-Centered Medical Home recognition from NCQA or Primary Care Medical Home certification from The Joint Commission.

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

8. **Style Requirements.** Submitted proposals must conform to the following specifications:

Binding Type:	Loose-leaf binders with the Legal Name of the Respondent, and the RFP Name appearing on the outside front cover of each binder: Medicaid Quality Improvement and Shared Savings Program (MQISSP) Participating Entities
Dividers:	A tab sheet keyed to the table of contents must separate each subsection of the proposal; the title of each subsection must appear on the tab sheet.
Paper Size:	8½" x 11", “portrait” orientation
Print Style:	1-sided
Font Size:	Minimum of 11-point
Font Type:	Arial or Tahoma
Margins:	The binding edge margin of all pages shall be a minimum of one and one half inches (1½"); all other margins shall be one inch (1").
Line Spacing:	Single-spaced

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

10. **Packaging and Labeling Requirements.** All proposals must be submitted in sealed envelopes or packages and be addressed to the Official Contact. The Legal Name and Address of the Respondent must appear in the upper left corner of the envelope or package. The RFP Name must be clearly displayed on the envelope or package: Medicaid Quality Improvement and Shared Savings Program Participating Entities Request for Proposals, (MQISSP_RFP).

    Any received proposal that does not conform to these packaging or labeling instructions will be opened as general mail. Such a proposal may be accepted by the Department as a clerical function, but it will not be evaluated. At the discretion of the Department, such a proposal may be destroyed or retained for pick up by the Respondents.

■ E. EVALUATION OF PROPOSALS

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

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

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

3. **Minimum Submission Requirements.** All proposals must comply with the requirements specified in this RFP. To be eligible for evaluation, proposals must (1) be received on or before the due date and time; (2) meet the Proposal Format requirements; (3) follow the required Proposal Outline; (4) be complete and (5) meet the requirements listed in the Executive Summary. Proposals that fail to follow instructions or satisfy these minimum submission requirements will not be reviewed further. The Department will reject any proposal that deviates significantly from the requirements of this RFP.

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

    - Organization
    - Enhanced Care Coordination Activities and Care Coordination Add-On Activities
    - Quality
    - Community and Clinical Integration Program
    - Data and Reporting
    - Financial Requirements
    - Appendices

5. **Respondent Selection.** Upon completing its evaluation of proposals, the Evaluation Team will submit the rankings of all proposals to the Department head. The final selection of a successful Respondent is at the discretion of the Department head. Any Respondent selected will be so notified and offered an opportunity to negotiate a contract with the Department. Such negotiations may, but will not automatically, result in a contract. Any resulting contract will be posted on the State Contracting Portal. All unsuccessful Respondents will be notified by email or U.S. mail, at the Department's discretion, about the outcome of the evaluation and Respondent selection process.

6. **Debriefing.** After receiving notification from the Department, any Respondent may contact the Official Contact and request a Debriefing of the procurement process and its proposal. If Respondents still have questions after receiving this information, they may contact the Official Contact and request a meeting with the Department to discuss the procurement process. The Department shall schedule and conduct Debriefing meetings that have been properly requested, within fifteen (15) days of the Department's receipt of

a request. The Debriefing meeting must not include or allow any comparisons of any proposals with other proposals, nor should the identity of the evaluators be released. The Debriefing process shall not be used to change, alter, or modify the outcome of a competitive procurement. More detailed information about requesting a Debriefing may be obtained from the Official Contact.

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

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

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

II. MANDATORY PROVISIONS

A. STANDARD CONTRACT, PARTS I AND II

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

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

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

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

Part I of the standard contract may be amended by means of a written instrument signed by the Department, the selected Respondent (contractor), and, if required, the OAG. Part II of the standard contract may be amended only in consultation with, and with the approval of, OPM and OAG.

B. ASSURANCES

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

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

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

3. **Competitors.** The Respondent assures that the submitted proposal is not made in connection with any competing organization or competitor submitting a separate

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

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

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

■ C. TERMS AND CONDITIONS

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

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

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

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

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

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

6. **Supplemental Information.** Supplemental information will not be considered after the deadline submission of proposals, unless specifically requested by the Department. The Department may ask a Respondent to give demonstrations, interviews, oral presentations, or further explanations to clarify information contained in a proposal. Any such demonstration, interview, or oral presentation will be at a time selected and in a place provided by the Department. At its sole discretion, the Department may limit the

number of Respondents invited to make such a demonstration, interview, or oral presentation and may limit the number of attendees per Respondent.

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

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

■ D. RIGHTS RESERVED TO THE STATE

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

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

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

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

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

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

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

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

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

■ E. STATUTORY AND REGULATORY COMPLIANCE

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

1. **Freedom of Information, C.G.S. § 1-210(b).** The Freedom of Information Act (FOIA) generally requires the disclosure of documents in the possession of the State upon request of any citizen, unless the content of the document falls within certain categories of exemption, as defined by C.G.S. § 1-210(b). Respondents are generally advised not to include in their proposals any confidential information. If the Respondent indicates that certain documentation, as required by this RFP in Section I.D.4 above, is submitted in confidence, the State will endeavor to keep said information confidential to the extent permitted by law. The State has no obligation to initiate, prosecute, or defend any legal proceeding or to seek a protective order or other similar relief to prevent disclosure of any information pursuant to a FOIA request. The Respondent has the burden of establishing the availability of any FOIA exemption in any proceeding where it is an issue. While a Respondent may claim an exemption to the State's FOIA, the final administrative authority to release or exempt any or all material so identified rests with the State. In no event shall the State or any of its employees have any liability for disclosure of documents or information in the possession of the State and which the State or its employees believe(s) to be required pursuant to the FOIA or other requirements of law.

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

   IMPORTANT NOTE: **The Respondent shall upload** the Workplace Analysis Affirmative Action Report through an automated system hosted by the Department of Administrative Services (DAS)/Procurement Division, and the Department of Social

Services can review said document online. The DAS guide to uploading affidavits and nondiscrimination forms online is embedded in this section as a hyperlink.

3. **Consulting Agreements, C.G.S. § 4a-81.** Proposals for State contracts with a value of $50,000 or more in a calendar or fiscal year, excluding leases and licensing agreements of any value, shall require a consulting agreement affidavit attesting to whether any consulting agreement has been entered into in connection with the proposal. As used herein "consulting agreement" means any written or oral agreement to retain the services, for a fee, of a consultant for the purposes of (A) providing counsel to a Contractor, vendor, consultant or other entity seeking to conduct, or conducting, business with the State, (B) contacting, whether in writing or orally, any executive, judicial, or administrative office of the State, including any Department, institution, bureau, board, commission, authority, official or employee for the purpose of solicitation, dispute resolution, introduction, requests for information or (C) any other similar activity related to such contract. Consulting agreement does not include any agreements entered into with a consultant who is registered under the provisions of C.G.S. Chapter 10 as of the date such affidavit is submitted in accordance with the provisions of C.G.S. § 4a-81. The Consulting Agreement Affidavit (OPM Ethics Form 5) is available on OPM's website at OPM: Ethics Forms
IMPORTANT NOTE: **The Respondent shall upload** the Consulting Agreement Affidavit (OPM Ethics Form 5) through an automated system hosted by the Department of Administrative Services (DAS)/Procurement Division, and the Department of Social Services can review said document online. The DAS guide to uploading affidavits and nondiscrimination forms online is embedded in this section as a hyperlink.

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

5. **Gift and Campaign Contributions, C.G.S. §§ 4-250 and 4-252(c); Governor M. Jodi Rell's Executive Orders No. 1, Para. 8 and No. 7C, Para. 10; C.G.S. § 9-612(g)(2).** If a Respondent is offered an opportunity to negotiate a contract with an anticipated value of $50,000 or more in a calendar or fiscal year, the Respondent shall fully disclose any gifts or lawful contributions made to campaigns of candidates for statewide public office or the General Assembly. Municipalities and CT State agencies are exempt from this requirement. The gift and campaign contributions certification (OPM Ethics Form 1) is available on OPM's website at OPM: Ethics Forms

   IMPORTANT NOTE: The selected Respondent shall upload the Gift and Campaign Contributions Certification (OPM Ethics Form 1) through an automated system hosted by the Department of Administrative Services (DAS)/Procurement Division prior to contract execution, and the Department of Social Services can review said document online. The DAS guide to uploading affidavits and nondiscrimination forms online is embedded in this section as a hyperlink.

6. **Nondiscrimination Certification, C.G.S. §§ 4a-60(a)(1) and 4a-60a(a)(1).** If a Respondent is offered an opportunity to negotiate a contract, the Respondent shall

provide the Department with *written representation* or *documentation* that certifies the Respondent complies with the State's nondiscrimination agreements and warranties. A nondiscrimination certification is required for all State contracts – regardless of type, term, cost, or value. Municipalities and CT State agencies are exempt from this requirement. The nondiscrimination certification forms are available on OPM's website at OPM: Nondiscrimination Certification

IMPORTANT NOTE: The selected Respondent shall upload the Nondiscrimination Certification through an automated system hosted by the Department of Administrative Services (DAS)/Procurement Division prior to contract execution, and the Department of Social Services can review said document online. The DAS guide to uploading affidavits and nondiscrimination forms online is embedded in this section as a hyperlink.

III. PROGRAM INFORMATION

A. DEPARTMENT OVERVIEW

The Department of Social Services (DSS) administers and delivers a wide variety of services to children, families, adults, people with disabilities and elders, including health care coverage, child support, long-term care and supports, energy assistance, food and nutrition aid, and program grants. DSS administers myriad state and federal programs and approximately one-third of the state budget, currently serving more than 950,000 individuals in 600,000 households (October 2014 data). By statute, the Department is the single State agency responsible for administering Connecticut's Medicaid program.

The Department administers most of its programs through 12 offices located in the three service regions, with central office support located in Hartford, Connecticut. The Department operates a service center where many of the services provided by the Department may be accessed via mail or telephone call.

1. Department Mission

Guided by shared belief in human potential, we aim to increase the security and well-being of Connecticut individuals, families, and communities.

2. Department Vision

To become a world-class service organization.

B. MEDICAID PROGRAM OVERVIEW

The Department's starting premise is that enabling Medicaid members to seamlessly access, and effectively utilize and coordinate, the broad range of services that is covered under Connecticut's Medicaid Program (also known, together with Connecticut's Children's Health Insurance Program, as HUSKY Health) will control costs. To this end, we are focusing on four key areas: a streamlined administrative Medicaid structure, access to primary, preventative care; integration of behavioral and medical care; and rebalancing of long-term services and supports.

1. Streamlined Administrative Structure

Why are we focusing here?

Historically, Connecticut Medicaid used a mix of managed care and fee-for-service arrangements to provide services to beneficiaries. Important features, such as rules concerning prior authorization of services, provider networks, and reimbursement rates for services, were not uniform across the managed care entities. This caused confusion and uncertainty for beneficiaries. Further, this lack of consistency posed challenges for providers who participated in more than one managed care network, and providers often reported that it was difficult to engage with the managed care companies and to get paid on a timely basis. Finally, the Department received only incomplete encounter data from the managed care companies, which did not give a complete or accurate view of the use of Medicaid services.

What are the key elements of work in this area?

Structure. By contrast to almost all other states, Connecticut no longer utilizes managed care arrangements, under which companies receive capitated payments for serving beneficiaries. Instead, Connecticut Medicaid is structured as a self-insured, managed fee-for-service model, through which the program contracts with four statewide Administrative Services Organizations (ASOs), respectively, for medical, behavioral, and dental health and for non-emergency medical transportation (NEMT) services. A percentage of each ASO's administrative payments is withheld by the Department pending completion of each fiscal year. To earn back these withholds, each ASO must demonstrate that it has achieved identified benchmarks on health outcomes, healthcare quality, and both member and provider satisfaction outcomes. An important feature of the ASO arrangement is that three of the ASOs provide Intensive Care Management (ICM), an intervention developed specifically to meet the diverse needs of our most socially and medically vulnerable members.

Data Analytics and Intensive Care Management. Employing a single, fully integrated set of claims data, which spans all coverage groups and covered services, Connecticut Medicaid takes full advantage of data analytic tools to risk stratify beneficiaries and to connect those who are at high risk or who have complex health profiles with ASO ICM support. Risk stratification is based on medical and pharmacy claims, member/ provider records, and results from diagnostic laboratory and imaging studies. Factors used to determine risk include: 1) overall disease burden (Adjusted Clinical Groups, or ACGs, measurement system); 2) disease markers (Expanded Diagnosis Clusters, or EDCs); 3) special markers (Hospital Dominant Conditions and Frailty); 4) medication patterns; 5) utilization patterns; and 6) age and gender.

ICM is structured as a person-centered, goal directed intervention that is individualized to each beneficiary's needs. Connecticut Medicaid's ICM interventions:

- integrate behavioral health and medical interventions and supports through co-location of clinical staff of the medical and behavioral health ASOs;
- augment Connecticut Medicaid's PCMH Program, through which primary care practices receive financial and technical support towards practice transformation and continuous quality improvement;
- are directly embedded in the discharge processes of a number of Connecticut hospitals;
- sustain the reduction of emergency department usage, inpatient hospital admissions and readmission rates;
- reduce utilization in confined settings (psychiatric and inpatient detoxification days) among individuals with behavioral health conditions; and
- reduce use of the emergency department for dental care, and significantly increase utilization of preventative dental services by children.

Interventions through our medical ASO, currently Community Health Network of Connecticut (CHN). The medical ASO utilizes a stratification methodology to identify members who presently frequent the emergency department (ED) for primary care and non-urgent conditions as well as those at risk of future use of acute care services. High risk members are defined as those who have claims data of seven (7) or more hospital emergency department (ED) visits in a rolling year; members with twenty (20) or more ED visits in a rolling year are defined as ED Super Users and are considered highest risk. ICM focuses on high risk members with multiple co-morbid, advanced, interrelated, chronic and/or behavioral (psychiatric and/or substance abuse) conditions. These members frequently exhibit instability in health status due to fragmented care among multiple providers, episodes or exacerbations and/or complications and impaired social, economic and material

resources and tend to have higher ED utilization. Many of these members are homeless and are in need of coordinated housing and access to health homes. Individuals with multiple chronic conditions benefit from an integrated plan of care that incorporates behavioral and non-medical supportive services.

Interventions through our behavioral health ASO, currently Beacon Health Options (formerly Value Options). Under the direction of the three state agencies that manage the Connecticut Behavioral Health Partnership (the Departments of Social Services, Mental Health and Addiction Services, and Children and Families), the behavioral health ASO used claims and other data to identify the five Connecticut hospitals that were associated with the greatest number of Medicaid high utilizers. The ASO then designed and implemented a multi-pronged approach to reduce the inappropriate use of the emergency department for individuals with behavioral health conditions. This approach includes 1) assigning ICM care managers to individuals who have visited the ED, with a primary or secondary behavioral health diagnosis, seven or more times in the six months prior to participation in ICM; 2) assigning peer specialists to members who could benefit from that support; and 3) dedicating a Regional Network Manager to help facilitate all-provider meetings to address the clinical and social support needs of the involved individuals. These provider meetings are multi-disciplinary and include, but are not limited to representatives from housing organizations, substance abuse and mental health providers, shelters, Federally Qualified Health Centers, and staff from the respective EDs.

Benefits of ASO structure. ASO arrangements have substantially improved beneficiary outcomes and experience through centralization and streamlining of the means of receiving support. The ASOs act as hubs for member support, location of providers, ICM, grievances and appeals. ASO arrangements have also improved engagement with providers, who now have a single set of coverage guidelines for each service, and a uniform fee schedule from which to be paid. Providers can bill every two weeks, and ‘clean claims’ are paid completely and promptly through a single fiscal intermediary – Hewlett Packard Enterprises. This promotes participation and retention of providers, as well as enabling monitoring of the adequacy of the networks needed to support a growing population of beneficiaries.

2. Access to Primary, Preventative Medical Care

Why are we focusing here?

Connecticut adults to not use primary care as indicated, with 1) 12% of at-risk Connecticut residents not having visited a doctor within the two years previous to the study; 2) considerably fewer people of color having done so; and 3) only half of Connecticut adults over age 50 are receiving recommended care. [Commonwealth Fund, 2009] Further, a report from the Connecticut Hospital Association indicated that one-third of all emergency department visits are for non-urgent health issues, and that 64% occur between 8:00 a.m. and 6:00 p.m., suggesting that there are barriers to accessing primary care even during typical work hours. [Connecticut Hospital Association, 2009]

What are the key elements of our work in this area?

- Person-Centered Medical Homes (PCMH). The Department implemented its Person-Centered Medical Home (PCMH) initiative on January 1, 2012. The premise of a PCMH is that it enables primary care practitioners to bring a holistic, person-centered approach to supporting the needs of patients, while reducing barriers to access (e.g. limited office hours) that have inhibited people from effectively using such care. Through this effort, the Department is investing significant resources to help primary care practices obtain

PCMH recognition from the National Committee for Quality Assurance (NCQA). Practices on the "glide path" toward recognition receive technical assistance from CHN CT. Practices that have received recognition are eligible for financial incentives including enhanced fee-for-service payments and retrospective payments for meeting benchmarks on identified quality measures. Key features of practice transformation include embedding limited medical care coordination functions within primary care practices, capacity for non-face-to-face and after hours support for patients, and use of interoperable electronic health records (EHR).

- Electronic Health Records (EHR). Another important aspect of enhancing the capacity of primary care is financial support for adoption of EHR. EHR supports more person-centered care and reduces duplication of effort across providers. DSS collaborates with the UConn Health Center to administer a Medicaid EHR Incentive Program. This includes review and approval of incentive payment applications from "Eligible professionals" (physicians, physician assistants, nurse practitioners, certified nurse-midwives, and dentists) as well as eligible hospitals. It also includes extensive outreach and education to providers, and support of other health IT efforts.
- Health Disparities Work. DSS and the Medicaid program's medical ASO are currently examining access barriers related to gender, race and ethnicity face by Medicaid beneficiaries. This project is focused on identifying disparities and equipping primary care practices with tools and strategies to reduce these barriers. DSS is also continuing to partner with the U.S. Office of Minority Health (OMH) on various efforts to improve the health of racial and ethnic populations through the development of policy and programming designed to eliminate disparities.

3. Integration of Medical, Behavioral Health, and Long-Term Services and Supports

Why are we focusing here?

Many Medicaid beneficiaries, especially those who are dually eligible for Medicare, have complex health profiles. A high incidence of beneficiaries have co-morbid physical and behavioral health conditions, and need support in developing goal-oriented, person-centered plans of care that are realistic and incorporate chronic disease self-management strategies. A siloed approach to care for a recipient's medical and behavioral health needs is unlikely to effectively care for either set of needs. For example, a client with depression and a chronic illness such as diabetes is unlikely to be able to manage either diabetes or depression without effectively addressing both conditions. Further, historically there has been considerable division as between medical and long-term services and supports, with little coordination or communication occurring among providers. DSS believes that the mind is part of the body, and that overcoming these boundaries is essential to responding in a person-centered manner to beneficiary needs, and to achieving better outcomes.

What are the key elements of our work in this area?

- Health Homes: DSS is working with the Department of Mental Health and Addiction Services to implement "health homes" for individuals with serious and persistent mental illness (SPMI). The federal Affordable Care Act built upon existing efforts to integrate medical, behavioral and social services and supports for individuals with behavioral health and chronic conditions by permitting states to seek approval of state plan amendments to implement such coverage. ACA "health home" amendments qualify states to receive eight quarters of enhanced Federal Medical Assistance Payment (FMAP) in support of this work (by contrast to the typical Connecticut FMAP of 50%, FMAP for health homes is at 90%). Health homes were implemented in Fall, 2015.

- Medicaid Quality Improvement and Shared Savings Program (MQISSP): See MQISSP Overview below.

4. Rebalancing of Long-Term Services and Supports (LTSS)

Why are we focusing here?

Consumers overwhelmingly wish to have meaningful choice in how they receive needed long-term services and supports. Connecticut's Medicaid spending remains weighted towards institutional settings, but re-balancing is shifting this. In State Fiscal Year 2014 (SFY'14), a total of $1.934 billion was spent in Connecticut on LTSS. This represented 11% of the state budget and 37% of the Medicaid budget. In SFY'14, 61% of beneficiaries of Medicaid LTSS received those supports in the community, but 29% of LTSS spending was attributable to these services. Rebalancing refers to reducing reliance on institutional care and expanding access to community Long-Term Services and Supports (LTSS). A rebalanced LTSS system gives Medicaid beneficiaries greater choice in where they live and from whom they receive services. It also delivers LTSS that are integrated, effective, efficient, and person-centered. Achieving a rebalanced LTSS system requires that states examine current policies, services, access, and other systemic elements that may present challenges to rebalancing goals.

What are the key elements of our work in this area?

In January, 2013, the Governor, the Office of Policy and Management and the Department of Social Services released the State's Strategic Plan to Rebalance LTSS. This plan details diverse elements of a broad agenda that is designed to support older adults, people with disabilities and caregivers in choice of their preferred means, mode and place in which to receive LTSS. Key aspects of the plan include 1) continued support for Money Follows the Person; 2) State Balancing Incentive Program (BIP) activities; 3) Testing Experience and Functional Tools (TEFT); 4) nursing home diversification; and 5) launch of a web-based hub called "My Place". The strategic plan also identifies 'hot spots' for development of services, including medical services, by projecting demand attributed to the aging population at a town level. Consistent with the U.S. Supreme Court's decision in Olmstead v. L.C., the rebalancing plan supports provision of services in the most integrated setting that is appropriate for each individual.

■ C. SIM OVERVIEW

In the State, SIM is a multi-payer approach to promote improved health care delivery. The development of the SIM initiative has been led by the SIM Project Management Office (PMO), located within the Office of the Healthcare Advocate, which serves under the leadership of the Lieutenant Governor. The development of SIM is supported by consultants and statewide advisory committees composed of payers, providers, consumers, and advocates.

In March 2013, the State received a planning grant from CMMI to develop a State Healthcare Innovation Plan (SHIP). Through the planning process, the PMO brought together a wide array of stakeholders who worked together to design a model for health care delivery supported by value-based payment methodologies with the goal of impacting care delivered to at least 80% of the entire State population within five years. The resultant SHIP outlines the goals and anticipated pathway to promote the Triple Aim for everyone in the

State: better health while eliminating health disparities, improved health care quality and experience, and reduction of growth in health care costs.

SIM was established as a means to ensure that health care reform initiatives are informed by the diversity and expertise that exists within Connecticut's stakeholder community—consumers, consumer advocates, employers, health plans, providers, and state agencies. The SIM governance structure and advisory process promotes multi-payer alignment so that payers and providers are pushing to achieve the same goals. SIM promotes alignment on methods and requirements where this makes sense (e.g., quality measures, medical home, and community integration), while also promoting flexibility and innovation.

■ D. MQISSP OVERVIEW

The Department will participate in the Connecticut SIM by implementing MQISSP. The goals of MQISSP are to improve health outcomes and care experience for Medicaid beneficiaries who are assigned to MQISSP using the methodology described below, and to contain the growth of health care costs. Specifically, MQISSP will build on DSS' existing PCMH model by incorporating new Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities related to the integration of primary care and behavioral health care, building provider competencies to support Medicaid beneficiaries with complex medical conditions and disability needs, and promoting linkages to community supports that can assist beneficiaries in utilizing their Medicaid benefits. Typical barriers that inhibit the use of Medicaid benefits include housing instability, food insecurity, lack of personal safety, limited office hours at medical practices, chronic conditions, and low literacy. Enabling connections to organizations that can support MQISSP members in resolving these access barriers will further the Department's interests in preventative health. Further, partnering with providers on this transformation will begin to re shape the paradigm for care coordination in a direction that will support population health goals for individuals who face the challenges of substance abuse and mental health, limited educational attainment, poverty, homelessness, and exposure to neighborhood violence.

NOTEWORTHY:
In order to implement MQISSP, the Department will seek applicable legal authority for Medicaid federal financial participation (FFP, also known as federal matching funds) from CMS, which may include one or more Medicaid State Plan Amendment(s), waiver(s), and/or other appropriate authority. In addition to the State's general right to amend this RFP at any time as detailed above, all elements of MQISSP are specifically subject to any and all changes that the Department may make, at any time, in connection with obtaining applicable legal authority for FFP from CMS, as the Department may deem necessary.

Under MQISSP, the Department will contract with qualified provider organizations to be MQISSP Participating Entities for an estimated 200,000 to 215,000 Medicaid beneficiaries in the Performance Period beginning January 1, 2017.

MQISSP will build on DSS' existing PCMH program by incorporating new Enhanced Care Coordination Activities and Care Coordination Add-On Activities related to the integration of primary care and behavioral health care, building provider competencies to support Medicaid beneficiaries with complex medical conditions and disability needs, and promoting linkages to community supports that can assist beneficiaries in utilizing their Medicaid benefits.

Under MQISSP, MQISSP Participating Entities will provide Enhanced Care Coordination Activities to improve the quality, efficiency, and effectiveness of care. FQHCs will also provide Care Coordination Add-On Payment Activities that are in addition to the Enhanced Care Coordination Activities and the care coordination activities that are already required for their participation in the DSS PCMH program (link to DSS PCMH program). All MQISSP Participating Entities (both FQHCs and Advanced Networks) that meet identified benchmarks on quality performance standards and measures of under-service will be eligible to participate in shared savings. DSS will also make Care Coordination Add-On Payments to MQISSP Participating Entities that are FQHCs to support the Care Coordination Add-On Payment Activities.

■ E. PROGRAM DESCRIPTION

1. Eligible Population

All Connecticut Medicaid beneficiaries are eligible for MQISSP except the beneficiary categories listed below:

- Behavioral Health Homes participants (Section 1945 of the Social Security Act).
- Full and partial Medicaid/Medicare dual eligibles.
- Home- and Community-Based Services Section 1915(c) waiver, Section 1915(i) and Section 1915(k) participants.
- Money Follows the Person participants.
- Beneficiaries that are enrolled in a hospice benefit.
- Residents of nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and other long-term care institutions that are required to coordinate care for their residents.
- Beneficiaries who are enrolled in Connecticut Medicaid solely to receive limited benefit package (current limited benefit packages are for family planning and tuberculosis). Similarly, beneficiaries who are enrolled in Connecticut Medicaid solely because they have breast or cervical cancer will also be excluded from MQISSP.

These beneficiaries will not be assigned to the MQISSP since these beneficiaries have another source of health care coverage, a limited Medicaid benefit, or receive care coordination through other programs.

2. Retrospective Attribution and Prospective Assignment Methodology

Eligible Medicaid beneficiaries (as described in Section III.E.1) will be assigned to MQISSP Participating Entities using DSS' existing retrospective attribution methodology that is used for primary care providers in Connecticut's Medicaid program (and is also the attribution methodology used for the PCMH program), adapted as necessary for MQISSP. The PCMH retrospective attribution methodology attributes a Medicaid beneficiary to a PCMH based on the beneficiary's active choice of provider (i.e., usual source of care). An MQISSP Participating Entity's attributed beneficiaries are the beneficiaries assigned to its PCMH practices using this methodology. Even if the MQISSP Participating Entity includes other providers, only the beneficiaries assigned to a PCMH will be considered to be the MQISSP Participating Entity's beneficiaries. Eligible Medicaid beneficiaries will be assigned to only one MQISSP Participating Entity. Eligible Medicaid beneficiaries will be assigned to an MQISSP Participating Entity on or around September 30, 2016 for the Performance Year starting January 1, 2017.

Beneficiaries will not be “enrolled” with an MQISSP Participating Entity. MQISSP Members will retain the ability to choose to see any qualified Medicaid provider. Members will be notified of this right through an established notification process. MQISSP Members will continue to be eligible for all services covered by the Connecticut Medicaid program, including those not included in the shared savings calculation.

Eligible Medicaid beneficiaries will have the ability to opt-out of prospective assignment to MQISSP. An eligible Medicaid beneficiary can opt-out either before the implementation date of MQISSP or at any time throughout the Performance Year. If an eligible Medicaid beneficiary opts-out of MQISSP, then that beneficiaries’ claim costs will be removed from the assigned MQISSP Participating Entity’s shared savings calculation and quality measurement. If an eligible Medicaid beneficiary opts-out of the MQISSP and that beneficiary’s assigned MQISSP Participating Entity was an FQHC, then that FQHC will no longer receive the Care Coordination Add-On Payment for that beneficiary. DSS is working to develop a process and tools to notify beneficiaries eligible for prospective assignment to MQISSP Participating Entities about MQISSP and their prospective assignment status. Participating Entities will be notified ahead of assignment.

3. Quality Strategy and Quality Measure Set

The Department’s MQISSP goals are to improve quality and the care experience of Medicaid beneficiaries. The Department worked with stakeholders to build an MQISSP quality strategy that is rooted in national best practices and Connecticut-specific data, including historical PCMH quality data. The MQISSP quality strategy, including a quality measure set (which includes measures of under-service), will be used to evaluate MQISSP Participating Entities’ performance and overall program success. The MQISSP Participating Entity’s ability to receive shared savings will be contingent on its quality score. For more information regarding the MQISSP shared savings payment methodology, see Section III.E.4 and Section III.E.7.

The current version of the MQISSP quality measure set can be found in **Attachment A** of this RFP. Data for the majority of quality measures, including Healthcare Effectiveness Data and Information Set (HEDIS) measures, will be collected from MQISSP Member claims and the Consumer Assessment of Healthcare Providers and Systems (CAHPS), conducted annually by DSS. Hybrid HEDIS measures (those measures that can be collected using both administrative data and medical record abstraction) will only be evaluated using administrative data at this time, although in the future the Department could move towards medical record abstraction. Quality measures used to determine shared savings payments in the first Performance Year will be limited to these claims-based measures. Quality Measures will be continuously evaluated and may be updated or revised for the second Performance Year and before the beginning of each Performance Year thereafter. For a description of how quality measure performance will be included in the shared savings calculation, see Section III.E.7.

MQISSP Participating Entities will only receive a shared savings payment if they meet identified benchmarks on quality performance standards and measures of under-service. Providers will be disqualified from receiving shared savings if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality. Please note that the criteria for identifying systemic under-service and panel manipulation is still under development.

4. Overview of Payment Methodology

MQISSP Participating Entities that are FQHCs will be reimbursed for Care Coordination Add-On Payment Activities by a Care Coordination Add-On Payment paid prospectively on a monthly basis for Care Coordination Add-On Payment Activities that the FQHC provides to MQISSP Members. MQISSP Participating Entities that are FQHCs will also be reimbursed for Enhanced Care Coordination Activities using the shared savings payment methodology.

MQISSP Participating Entities that are Advanced Networks will be reimbursed for Enhanced Care Coordination Activities using the shared savings payment methodology. Advanced Networks will not be eligible to receive the Care Coordination Add-On Payment. Primary care providers within an Advanced Network can receive a portion of the MQISSP Participating Entity's shared savings only for program years for which such provider has maintained full DSS PCMH recognition throughout the program year (see Section III.F.1.a.ii).

Both FQHCs and Advanced Networks will continue to receive standard payments under the Connecticut Medicaid program using the standard payment methodology or methodologies applicable to the provider for services provided to Medicaid beneficiaries.

5. Care Coordination Add-On Payment Methodology

DSS will make Care Coordination Add-On Payments prospectively on a monthly basis to MQISSP Participating Entities that are FQHCs. These payments will provide financial support to help FQHCs make the necessary investments to provide Care Coordination Add-On Payment Activities as detailed below in Section III.F.4. The Care Coordination Add-On Payments are appropriation-limited; the amount of the payment will depend on the number of MQISSP Participating Entities that are FQHCs and the size of their attributed MQISSP membership.

The Care Coordination Add-On Payment Activities will only be required of MQISSP Participating Entities that are FQHCs. These activities are in addition to care coordination activities required under HRSA standards for FQHCs, under criteria for Patient-Centered Medical Home recognition from NCQA or Primary Care Medical Home certification from The Joint Commission, and by an FQHC's participation in the DSS PCMH program. The Care Coordination Add-On Payment Activities are also in addition to the Enhanced Care Coordination Activities required of all MQISSP Participating Entities.

DSS will not factor the Care Coordination Add-On Payments in an FQHC's shared savings calculation. The Care Coordination Add-On Payments are separate from the payments that an FQHC may receive from the shared savings payment methodology.

6. Benefits Included in the Shared Savings Calculation

The MQISSP Participating Entity's shared savings calculation includes the cost of a defined set of benefits that is the same for all MQISSP Participating Entities. MQISSP Participating Entities do not need to deliver all benefits; rather, the cost of these benefits will be included in the MQISSP Participating Entity's shared savings calculation. MQISSP Participating Entities may impact the cost of these benefits through the provision of Enhanced Care Coordination Activities and addressing the social determinants of health through implementing linkages to community partners.

All Medicaid claim costs for covered benefits will be included in the shared savings calculation for the MQISSP Participating Entity, with the exception of:

- Hospice;
- Long-term services and supports, including institutional and community-based services; and
- Non-emergency medical transportation.

MQISSP Members will continue to be eligible for all benefits covered by the Connecticut Medicaid program, including those listed above that are excluded from the shared savings calculation, and will retain free choice of all qualified Medicaid providers.

7. Shared Savings Payment Methodology

The shared savings payment methodology will adhere to the following guiding principles:

- Only MQISSP Participating Entities that meet identified benchmarks on quality standards and measures of under-service will be eligible to participate in shared savings.
- MQISSP Participating Entities will be disqualified from receiving shared savings if any of their providers is found to be underserving or manipulating their panel.
- Maintaining and improving quality will factor into the calculation of shared savings.
- Higher quality scores will allow an MQISSP Participating Entity to receive more shared savings.
- MQISSP Participating Entities that demonstrate losses (i.e., increased expenditures incurred by Connecticut Medicaid) will not be required to share in losses (i.e., will not be required to return any portion of such increased expenditures to the Department).
- MQISSP Participating Entities will be benchmarked for quality and cost against a comparison group.

If an MQISSP Participating Entity generates savings for the Connecticut Medicaid program and meets applicable measures of quality and under-service, that MQISSP Participating Entity will share in the savings achieved. Savings will be available to MQISSP Participating Entities through two savings “pools.” The first pool will be an individual savings pool, where each MQISSP Participating Entity that meets the quality benchmarks will receive a portion of the savings it achieved individually. The second pool will be a challenge pool that will aggregate all savings not awarded to individual MQISSP Participating Entities in the individual pool due to failure to meet identified benchmarks on quality performance standards.

a. Individual Savings Pool

An MQISSP Participating Entity’s individual savings pool will be funded by the savings generated by each MQISSP Participating Entity. The MQISSP Participating Entity’s shared savings payment in the individual pool will be determined by the MQISSP Participating Entity's aggregate quality score. The aggregate quality score will be developed based on the MQISSP Participating Entity's performance on three components of quality measurement (maintain quality, improve quality, and absolute quality) for each of nine quality measures, the current version of which is listed in **Attachment A**. An MQISSP Participating Entity will receive its savings from the individual savings pool in accordance with the model described below:

- The twelve month time period for the Prior Year will be January 1, 2016 through December 31, 2016.
- The twelve month time period for the Performance Year will be January 1, 2017 through December 31, 2017.
- There will be no minimum savings rate that an MQISSP Participating Entity must achieve.
- Each individual savings pool will be limited to ten percent (10%) of the MQISSP Participating Entity's expected Performance Year costs.
- A sharing factor (the amount of savings shared between an MQISSP Participating Entity and DSS) of fifty percent (50%) will apply to each MQISSP Participating Entity's savings.
- The annual claims cost for each eligible Medicaid beneficiary assigned to an MQISSP Participating Entity will be truncated at $100,000 so that costs above $100,000 will not be included in the shared savings calculation.
- Expected cost trends will be developed from a comparison group. The expected cost trends from the comparison group will be based upon both the Performance Year and the Prior Year, described above.
- Concurrent risk adjustment scores will be used to calculate the change in relative risk from the Prior Year to the Performance Year using statistical risk adjustment software. Risk scores will be calculated for each MQISSP Participating Entity and the comparison group. Normalized risk scores will then be calculated so that each MQISSP Participating Entity's level of risk can be compared relative to other MQISSP Participating Entities and to the comparison group. Using the change in relative risk, the shared savings calculation will be adjusted based on the increase or decrease in the risk of the attributed populations.
- The shared savings calculation is an upside-only model, meaning that an MQISSP Participating Entity will not be required to share in costs that exceed their expected risk-adjusted Performance Year costs (i.e., the Participating Entity will not be required to return any portion of increased expenditures incurred by the Connecticut Medicaid program).
- An aggregate quality score will be calculated for each MQISSP Participating Entity based on three components (maintain quality, improve quality, and absolute quality) of quality measurement for each of the nine quality measures. Points will be earned for each component of quality measurement. There will be a maximum of three points that can be earned for each quality measure, with one point for each component of quality measurement. With nine quality measures, this yields twenty-seven possible points that an MQISSP Participating Entity could earn to determine the amount of its payment in the individual savings pool.
- The three components of quality measurement in the individual savings pool are:
    - Maintain Quality
        - For the Maintain Quality component of measurement, an MQISSP Participating Entity will earn one point if its Performance Year quality score is greater than or equal to its Prior Year score. A threshold will be established based on historical quality measure data to account for annual variation that results in a lower score.

- Improve Quality
  - For the Improve Quality component of measurement, an MQISSP Participating Entity will earn points on a sliding scale based on performance against the comparison group's quality trend.

Improvement above the comparison group's quality trend	Points Awarded
Less than or equal to comparison group's quality trend	0.00
Between 0% and 32%	0.25
Between 33% and 66%	0.50
Between 67% and 99%	0.75
100% or greater	1.00

- Absolute Quality
  - For the Absolute Quality component of measurement, an MQISSP Participating Entity will earn points on a sliding scale based on performance against the benchmarks developed from the comparison group's historical quality measure data.

Percentile	Points Awarded
Between 0 and 49.99	0.00
Between 50 and 59.99	0.25
Between 60 and 69.99	0.50
Between 70 and 79.99	0.75
Between 80 and 99.99	1.00

To determine if cost savings were generated during the Performance Year, for each MQISSP Participating Entity, risk-adjusted Performance Year costs will be compared to expected Performance Year costs. An MQISSP Participating Entity's expected Performance Year costs will be developed by applying the comparison group cost trend to the MQISSP Participating Entity's Prior Year costs. If the MQISSP Participating Entity's Performance Year costs are lower than its expected Performance Year costs, then the MQISSP Participating Entity will have a risk-adjusted savings that will go to its individual savings pool. However, if such savings exceed ten percent (10%) of the of the MQISSP Participating Entity's expected Performance Year costs, the amount above 10% will not be included in the pool. If there are savings in the individual savings pool, the sharing factor will be applied, and then the MQISSP Participating Entity's aggregate quality score will be applied. The savings amount after both of these factors have been applied will be the MQISSP Participating Entity's shared savings. If an MQISSP Participating Entity has any savings that go unclaimed due to performance on the quality measures (its aggregate quality score), then those unclaimed savings will be used to fund the challenge pool.

b. Challenge Pool
The challenge pool will be funded by all unclaimed savings from the individual savings pools. Performance on four quality measures, listed in Attachment A, will inform the challenge pool payment through the use of a member-weighted distribution by MQISSP Participating Entity. For each quality measure, an MQISSP Participating Entity must achieve at least the median score of all MQISSP Participating Entities that are participating in the challenge pool, for that measure to be counted within the member-weighted distribution. The four quality measures used for the challenge pool are a separate set of quality measures than the nine quality measures used in the individual savings pool.

8. Monitoring and Oversight

MQISSP Participating Entities will be subject to reporting requirements, which are currently under development. The reporting requirements will be incorporated into the contract with MQISSP Participating Entities.

DSS will develop and implement methods to monitor delivery of Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities. MQISSP Participating Entities will be responsible for reporting data to DSS on a regular (e.g., monthly or quarterly) basis as specified in the Contract. DSS program staff will review the reports and follow up with MQISSP Participating Entities as needed regarding their performance. MQISSP Participating Entities that do not provide sufficient evidence of performing the required Enhanced Care Coordination Activities, as determined by DSS, may be ineligible to participate in shared savings. MQISSP Participating Entities that are FQHCs that do not provide sufficient evidence of performing the FQHC Care Coordination Add-On Payment Activities may be subject to a corrective action plan and may be ineligible to participate in shared savings.

9. Community and Clinical Integration Program (CCIP)

The State Innovation Model (SIM) program is a Centers of Medicare & Medicaid Innovation (CMMI) initiative to support the development and implementation of multi-payer healthcare payment and service delivery model reforms that will improve health system performance, increase quality of care, and decrease costs in participating states. As part of this program, Connecticut released its State Healthcare Innovation Plan (SHIP) articulating a vision to transform healthcare by establishing a whole-person-centered healthcare system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and healthcare; and improves affordability by reducing health care costs. In 2014 Connecticut received a $45 million State Innovation Model (SIM) grant from the Centers of Medicare & Medicaid Innovation (CMMI) to implement its plan for achieving this vision over a four year period (2015-2019)

A comprehensive report describing the CCIP program and associated standards is available at http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2741&q=335990.

The State Innovation Model (SIM)-funded Community and Clinical Integration Program (CCIP) establishes care delivery standards and will provide technical assistance (TA) in support of a) improving care for individuals with complex health needs, b) introducing new care processes to reduce health equity gaps, and c) improving access to and integration of behavioral health services. DSS has agreed to embed requirements related to CCIP standards within this Request for Proposals (RFP). DSS' reason for doing so is that it acknowledges the value of promoting activities that will promote and support the needs of Medicaid beneficiaries who are already being served by advanced

networks. DSS and the SIM PMO also agree, however, that it will be useful to test the CCIP standards to ascertain whether concerns that have been raised around cost and specificity have, or do not have, merit. Therefore, in the first wave of MQISSP procurement for the project period starting January 1, 2017, DSS and the SIM PMO have agreed permit applicant entities to choose whether or not they will be bound by the CCIP standards. The RFP offers two tracks, from which applicant entities must choose. The first track will require Participating Entities to participate in CCIP technical assistance, but will not require demonstrated achievement of the CCIP standards as a condition for continued participation in MQISSP. The other will enable Participating Entities to indicate that they agree to be bound by CCIP standards. Over the course of the first MQISSP performance period, DSS and the SIM PMO will carefully review the experience of Participating Entities that agree to be bound by the CCIP standards, will seek additional comment on the CCIP standards, and may adjust the CCIP standards, as needed. For the second wave MQISSP procurement, achievement of the CCIP standards, as revised, will be a condition for all MQISSP Participating Entities.

POLICY	TRACK 1	TRACK 2
CCIP commitment	Respondents commit to participate in the CCIP TA program, which will be tailored to their individual needs, but are <u>not</u> required to achieve the CCIP core standards until 15 months from the start date of the second wave of MQISSP	Respondents commit to participate in the CCIP TA program, which will be tailored to their individual needs, <u>and</u> to achieve the core CCIP standards within 15 months of the MQISSP start date (anticipated to be 1/1/17)
MQISSP RFP requirements	Respondents will be asked to describe how they will organize and manage the transformation process and work with the TA vendor to *make progress toward* the core standards	Respondents will be asked to describe how they will organize and manage the transformation process and work with the TA vendor to *achieve* the core standards
Funding	Respondents will receive no-cost TA and will have the opportunity to participate in a learning collaborative, but are not eligible for SIM-funded transformation awards	Respondents will receive no-cost TA, will have the opportunity to participate in a learning collaborative, and will have the opportunity to apply for up to $500,000 per applicant in SIM-funded transformation awards
Compliance monitoring	Respondents will be surveyed regarding their progress on activities related to the standards, for purposes of PMO reporting to CMMI	Respondents will participate in a validation survey; achievement of standards <u>will be</u> a condition of continued participation in MQISSP

POLICY	TRACK 1	TRACK 2
Accommodations	N/A	Providers that elect to be bound by the CCIP standards may request a waiver or accommodations with respect to specific requirements. These are summarized at http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2741&q=335990

The three areas of CCIP core standards are:

- Comprehensive care management: The standards establish a person-centered process for identifying and managing the care of individuals with complex health care needs, including using multi-disciplinary comprehensive care teams. They will enable medical homes to more effectively identify individuals who will benefit from comprehensive care management, engage those individuals, and coordinate services by using an expanded care team that includes community-based service and support providers
- Health equity improvement: Part 1 of these standards focus on continuous health equity gap improvement including analytic capabilities to routinely identify disparities in care, conduct root cause analyses to identify the best interventions, and develop the capabilities to monitor the interventions. Part 2 specifies an intervention that uses a community health worker to address an identified equity gap.
- Behavioral health integration: These standards incorporate best-practice processes to identify unidentified behavioral health needs in the primary care setting. This program seeks to bolster the ability of providers to perform these functions while optimizing existing resources. The standards establish a process for identifying individuals with unidentified behavioral health needs and addressing the need.

The three areas of CCIP elective standards are:

- E-Consults: E-consults is a telehealth system in which primary care providers consult with a specialist reviewer electronically via e-consult prior to referring an individual to a specialist for a face to face non-urgent care visit. E-consult provides rapid access to expert consultation. This can improve the quality of primary care management, enhance the range of conditions that a primary care provider can effectively treat in primary care, and reduce avoidable delays and other barriers (e.g., transportation) to specialist consultation.

- Comprehensive Medication Management (CMM): This intervention is intended to improve care for patients with complex drug therapy regimens who would benefit from a comprehensive personalized medication management plan. CMM is a system-level, person-centered process of care provided by credentialed pharmacists to optimize the complete drug therapy regimen for a patient's given medical condition, socio-economic conditions, and personal preferences. The model depends on pharmacists working collaboratively with physicians and other

healthcare professionals to optimize medication use in accordance with evidence-based guidelines.

- Oral Health Integration: These standards provide best-practice processes for the primary care practices to routinely perform oral health assessment with recommendations for prevention, treatment, and referral to a dental home.

A description of the technical assistance and change management processes and a complete list of the CCIP standards in each of these core and elective areas can be found at http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2741&q=335990.

General CCIP Requirements

Track 1 and Track 2 CCIP participating entities will be required to meet the following expectations throughout the period of performance:

- Participate in technical assistance and the creation and implementation of a Transformation Plan to make progress towards (Track 1) or achieve (Track 2) core standards, and any chosen elective standards.
- Identify and deploy a committed leadership team in the network that will steward the CCIP change process.
- Coordinate with the CCIP transformation vendors and participate in quality improvement activities, including regular webinars, events, office hours and others.
- Undertake the internal care delivery transformation process including engaging practices, modifying policies and procedures, modifying clinical workflows and health information systems, and providing clinical and quality improvement expertise and training to clinical staff.
- Deploy care delivery interventions across all populations, regardless of payer, while ensuring the best interests of Medicaid beneficiaries.

A draft CCIP Transformation Services Agreement can be found at http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2741&q=335990.

Note: As described above, CCIP standards are part of the requirements for Participating Entities to participate in MQISSP. However, the CCIP requirements do not affect the Department's policies or reimbursement methodology outside of MQISSP. Accordingly, the Department may choose to reimburse separately for one or more services provided by one or more categories of providers, even if the service is included as part of the CCIP requirements.

F. MQISSP PARTICIPATING ENTITY REQUIREMENTS

1. Organizational Requirements of MQISSP Participating Entities

To be eligible to participate in MQISSP, Respondents must meet the minimum requirements for all MQISSP Participating Entities plus the criteria for either an FQHC or an Advanced Network, as applicable to the Respondent. The Department will only enter into contracts under MQISSP with FQHCs and Advanced Network Lead Entities (on behalf of Advanced Networks) that meet minimum requirements. MQISSP Participating Entities may have common or diverse ownership (i.e., the MQISSP Participating Entity may be comprised of one or multiple provider organizations, whether or not these organizations are part of one common system or ownership).

The following paragraphs are informational as well as required in the Executive Summary as minimum submission requirements. To qualify for participation in MQISSP, each MQISSP Participating Entity is required to:

- Have at least 2,500 DSS PCMH Program attributed beneficiaries who are eligible to participate in MQISSP;
- Ensure that only providers enrolled in Connecticut Medicaid are providing Medicaid services to MQISSP Members (link to Connecticut Medical Assistance Program Provider Enrollment website); and
- Have an oversight body that may, but is not required to, overlap with an existing governing board or an existing advisory body. The oversight body must include substantial representation by MQISSP Members assigned to the MQISSP Participating Entity and at least one provider participating in the MQISSP Participating Entity. The type and number of providers on the oversight body need not be proportional to MQISSP Participating Entity participating providers, but must be generally representative of the variety of providers participating in the MQISSP Participating Entity (e.g., primary care, other physical health providers, behavioral health providers, oral health providers, etc.). The oversight body must:
  a. Meet at least quarterly and provide meaningful feedback to the MQISSP Participating Entity on a variety of topics, including quality improvement, member experience, prevention of underservice, implementation of MQISSP, and distribution of shared savings.
  b. Have a transparent governing process;
  c. Have bylaws that reflect the oversight body's structure as well as define its ability to support the MQISSP objectives;
  d. Have a conflict of interest policy calling for disclosure of relevant financial interests and a procedure to determine whether conflicts exist and an appropriate process to resolve conflicts.

  The MQISSP Participating Entity must provide assistance to MQISSP Members to enable them to attend oversight body meetings (including such assistance as transportation and childcare). The MQISSP Participating Entity must circulate relevant written reports and materials in advance to the members of the oversight body. The MQISSP Participating Entity must have formal procedures through which to receive feedback from the oversight body and documentation of this communication must be made available to DSS upon request.

In addition to the minimum requirements listed above for all MQISSP Participating Entities, each MQISSP Participating Entity must also meet at least the following minimum requirements for either an Advanced Network or an FQHC:

a. Advanced Network must, at a minimum:

i. Include one or more practice(s) that is/are currently participating in the DSS PCMH program as a PCMH and hold/holds Level 2 or 3 Patient-Centered Medical Home recognition from NCQA. Practices with Glide Path designation, which is a step towards DSS PCMH recognition, do not count as meeting this requirement. Each PCMH practice may participate in only one Advanced Network and cannot change during a Performance Year. Advanced Networks are encouraged to include additional providers, and will be required in the response to this RFP to include signed letters of intent for each provider included in the Advanced Network. Acceptable options for Advanced Network composition include:
(1) One or more DSS PCMH practice(s);
(2) One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health, and oral health providers;
(3) One or more DSS PCMH practice(s) plus specialist(s) (which could include physical health, behavioral health and oral health providers) and one or more hospital(s); or
(4) A Medicare ACO that includes one or more DSS PCMH practice(s).

ii. Require any non-DSS PCMH primary care practices within the Advanced Network to become a DSS PCMH practice within eighteen (18) months of the start of the first MQISSP Performance Year. This is a multi-step process. First, any non-DSS PCMH primary care practices must apply to the DSS PCMH Glide Path at the start of the first Performance Year. In general, this process includes three steps: (1) the primary care practice completes a readiness review questionnaire; (2) within 30 days, the practice completes the PCMH program application; (3) within 30 days, the practice completes a detailed Glide Path application that includes high levels steps and timeline to achieving PCMH recognition for the practice. The target date for a primary care practice to complete these steps is February 28, 2017. Additional information about the DSS PCMH program, including resources and supports for practices on the Glide Path can be found at http://www.huskyhealthct.org/providers/pcmh.html. DSS retains the right to extend the timeframe for PCMH recognition based on good cause shown by a practice for why it needs additional time. Practices that do not achieve this milestone will be issued a corrective action plan. The corrective action plan will establish timeframes for the practice(s) to address gaps in order to become a DSS PCMH. DSS will monitor compliance with the corrective action plan until DSS PCMH status has been reached. Non-compliance with corrective action plans will result in termination of the Advanced Network's contract with DSS, and loss of shared savings for that performance year.

iii. Designate an Advanced Network Lead Entity that is a provider or provider organization participating in the Advanced Network. The Advanced Network Lead Entity must:
(1) Identify a clinical director and a senior leader to represent the Advanced Network and champion MQISSP goals. These positions are not required

to be full time or solely dedicated to MQISSP. The appointment and removal of the clinical director and senior leader must be under the control of the Advanced Network's oversight body;

(2) Ensure that the required Enhanced Care Coordination Activities are implemented as intended, including but not limited to: ensuring required staff are hired and appropriately trained, monitoring of day-to-day practice, establishment of linkages with community partners, and any required reporting to DSS;

(3) Enter into a contract with DSS;

(4) Receive any shared savings achieved and distribute the shared savings to Advanced Network participating providers, using a written distribution methodology that is subject to review and approval by the Department; and

(5) If the Advanced Network is comprised of more than one provider organization, have a contractual relationship with all other Advanced Network participating providers for the purposes of MQISSP. The contract must at a minimum contain:

(a) An explicit requirement that each Advanced Network participating provider agrees to participate in and comply with the applicable requirements of the MQISSP;

(b) A description of the Advanced Network participating provider's rights and obligations in, and representation by, the Advanced Network Lead Entity, including language giving the Advanced Network Lead Entity the authority to terminate a provider's participation in the Advanced Network for its non-compliance with the Advanced Network participation agreement or any of the requirements of Connecticut Medicaid;

(c) Language that Advanced Network participating providers must allow MQISSP Members freedom of choice of provider and may not require that members be referred to providers within the Advanced Network; and

(d) A description of the methodology for distributing any shared savings between the Advanced Network Lead Entity and Advanced Network participating providers. The shared savings distribution methodology must not include any factors that would reward a provider for specific contributions to the overall savings of the network. Non-DSS PCMH primary care practices in the Advanced Network may not receive a portion of any shared savings achieved by the Advanced Network. This methodology is subject to review and approval by the Department.

b. FQHC must, at a minimum:

i. Meet all requirements of an FQHC under section 1905(l)(2)(B) of the Social Security Act,

ii. Have either: (A) HRSA grant funding as an FQHC under Section 330 of the PHSA or (B) HRSA designation as an FQHC Look-Alike,

iii. Operate in Connecticut and meet all federal and state requirements applicable to FQHCs;

iv. Be a current participant in the DSS PCMH program (Glide Path practices are excluded) and hold current Level 2 or 3 Patient-Centered Medical Home

recognition from NCQA or Primary Care Medical Home certification from The Joint Commission.

v. Identify a clinical director and senior leader to represent the FQHC and champion MQISSP goals. These positions are not required to be full time or solely dedicated to the FQHC.

FQHCs may not limit a member's ability to receive services from a provider that is not affiliated with the FQHC.

2. Linkages with Community Partners to Address Social Determinants of Health

In an effort to meaningfully impact the social determinants of health, promote physical and behavioral health integrated care, and assist beneficiaries in utilizing their Medicaid benefits, MQISSP Participating Entities will be required to implement or demonstrate contractual relationships or informal partnerships with local community partners, including:

- Community-based organizations including organizations that assist the community with housing, clothing, utility bill assistance, nutrition, food assistance, employment assistance, education, child care, transportation, language and literacy training, elder support services, etc.;
- Behavioral health organizations, including those providing substance use services;
- Child-serving organizations;
- Peer support services and networks;
- Social services agencies;
- The criminal justice system;
- Local public health entities;
- Specialists and hospitals (in cases where the Advanced Network does not already include these entities); and
- Other State and local programs, both medical and non-medical.

The purpose of these partnerships will be to develop and implement initiatives to identify and actively refer members with behavioral health conditions that require specialized behavioral health treatment to appropriate sources of care, address social determinants of health, and facilitate rapid access to care and needed resources.

3. Enhanced Care Coordination Activities

MQISSP Participating Entities will provide Enhanced Care Coordination Activities to MQISSP Members. The Enhanced Care Coordination Activities leverage national best practices in care coordination and exceed the FQHC, HRSA, and Patient-Centered Medical Home recognition requirements as defined by NCQA or ambulatory care entities with a Primary Care Medical Home certification from The Joint Commission.

All MQISSP Participating Entities must perform the required Enhanced Care Coordination Activities. MQISSP Participating Entities that are FQHCs will provide both the Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities, described in Section III.F.4, which will be reimbursed through the Care Coordination Add-On Payment.

The following Enhanced Care Coordination Activities will be required of both FQHCs and Advanced Networks:

a. Behavioral Health/Physical Health Integration

i. Employ a care coordinator with behavioral health education, training, and/or experience who participates as a member of the interdisciplinary team.

ii. Use standardized tools to expand behavioral health screenings beyond depression.

iii. Promote universal screening for behavioral health conditions across all populations, not just those traditionally identified as high risk.

iv. Obtain and maintain a copy of a member's psychiatric advance directive in the member's file.

v. Obtain and maintain a copy of a member's Wellness Recovery Action Plan (WRAP) in the member's file.

b. Culturally Competent Services

i. Require annual cultural competency training for all practice staff. Cultural competency training will include the needs of individuals with disabilities.

ii. Expand any individual care plan currently in use to include an assessment of the impact culture has on health outcomes.

iii. Require compliance with culturally and linguistically appropriate services (CLAS) standards as defined by the U.S. Department of Health and Human Services, Office of Minority Health (see **Attachment B** for the CLAS standards).

c. Care Coordinator Staff Requirements: Availability — Providers must select at least one of these options based on the model(s) that fit their practice:

i. Employ a full time care coordinator dedicated solely to care coordination activities.

ii. Assign care coordination activities to multiple staff within a practice.

iii. Contract with an external agency to work with the practice to provide care coordination.

d. Care Coordinator Staff Requirements: Education

i. Define minimum care coordinator education and experience requirements and determine if leveraging non-licensed staff such as community health workers is desired.

e. Children and Youth with Special Healthcare Needs[1] (CYSHCN): Age 0–17 Years

i. Require advance care planning discussions for CYSHCN. Advance care planning is not limited to CYSHCN with terminal diagnoses. It can occur with CYSHCN with chronic health conditions, including behavioral health conditions, that significantly impact the quality of life of the child/youth and his/her family.

[1] Maternal Child and Health Bureau definition of CYSHCN: "Those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. " This definition is broad and inclusive, and it emphasizes the characteristics held in common by children with a wide range of diagnoses. Examples include children with diagnoses such as diabetes or asthma that is not well controlled. http://mchb.hrsa.gov/cshcn05/

ii. Develop advance directives for CYSHCN.

iii. Include school-related information in the member's health assessment and health record, such as: the individualized education plan or 504 plan, special accommodations, assessment of patient/family need for advocacy from the provider to ensure the child's health needs are met in the school environment, how the child is doing in school and how many days have been missed due to the child's health condition, and documenting the school name and primary contact.

f. Competencies in Care of Individuals with Disabilities (inclusive of physical, intellectual, developmental and behavioral health needs)

i. Expand the health assessment to include questions about: durable medical equipment (DME) and DME vendor preferences, home health medical supplies and home health vendor preferences, home and vehicle modifications, prevention of wounds for individuals at risk for wounds, and special physical and communication accommodations needed during medical visits.

ii. Adjust appointment times for individuals who require additional time to address physical accommodations, communication needs, and other unique needs for individuals with disabilities. Individuals may be seen by the primary care physician and other members of the interdisciplinary team during these adjusted appointment times.

iii. Develop and require mandatory disability competency trainings to address the care of individuals with physical and intellectual disabilities.

iv. Acquire accessible equipment to address physical barriers to care (e.g., wheelchair scales, a high/low exam table and/or transfer equipment, and lifts to facilitate exams for individuals with physical disabilities).

v. Address communication barriers to care (e.g., offer important medical information and documents in Braille or large print, implement policies to ensure services animals are permitted into an appointment). Providers may coordinate with the Department's medical Administrative Services Organization to obtain available materials.

vi. Expand the resource list of community providers to include providers who specialize in or demonstrate competencies in the care of individuals with disabilities (e.g., mammography centers that can accommodate women who use wheelchairs, providers who will take the time to help a patient with cerebral palsy who experiences spasticity or tremors during a physical examination).

g. Evaluate and utilize the results of provider profile reports, to the extent available, on a quarterly basis to improve quality of care.

4. Care Coordination Add-On Payment Activities

The following Care Coordination Add-On Payment Activities will only be required of MQISSP Participating Entities that are FQHCs:

a. Behavioral Health/Physical Health Integration

i. Employ a care coordinator with behavioral health experience who serves as a member of the interdisciplinary team and has the responsibility for tracking

patients, reporting adverse symptoms to the team, providing patient education, supporting treatment adherence, taking action when non-adherence occurs or symptoms worsen, delivering psychosocial interventions, and making referrals to behavioral health services outside of the FQHC as needed.

ii. Develop WRAPs in collaboration with the patient and family.

b. Transition-Age Youth (TAY). Expand the development and implementation of the care plan for TAY with behavioral health challenges (e.g., collaborative activities to achieve success in transition and/or referrals to and coordination with programs specializing in the care of TAY with behavioral health challenges).

c. Require the use of an interdisciplinary team that includes behavioral health specialist(s), including the required behavioral health coordinator position.

i. Demonstrate that the interdisciplinary team has the responsibility for driving physical and behavioral health integration, conducting interdisciplinary team case review meetings at least monthly, promoting shared appointments and developing a comprehensive care plan outlining coordination of physical and behavioral health care needs.

■ G. MAIN PROPOSAL COMPONENTS – The Department is encouraging responses to be as brief as possible due to the variations of different types of entities throughout all requirements.

1. Organization

A responsive proposal must include the following information about the Respondent's organizational capabilities.

a. Overview

i. Provide a brief overview of the Respondent's organization including:

(1) A brief description of the Respondent's purpose, mission, and vision and how it aligns with MQISSP.

(a) If the Respondent is an Advanced Network Lead Entity, also describe how the purpose, mission, and vision of the Respondent align with the Advanced Network's purpose, mission, and vision;

(2) A description of the Respondent's organization including whether the Respondent is an independent entity or an affiliate, subsidiary, or division of another entity (if the Respondent is not an independent entity, describe the Respondent's linkages with the other entities and the degree of integration/collaboration between the Respondent and the other entities).

(a) Provide an organizational chart showing the proposed structure (or existing structure, if applicable) of functions and positions by title within the Respondent's organization as it relates to MQISSP. Indicate which portions of the structure are currently in place and which portions are proposed to be created. Include a narrative summary of the proposed collaboration within the Respondent's organization related to MQISSP.

(b) If the Respondent is an Advanced Network Lead Entity, briefly describe the composition of the proposed Advanced Network including any other providers that will participate in the Advanced Network. Complete Attachment C. ADVANCED NETWORK PROVIDER FORM, and include as **Appendix A** of your response. Submit signed letters of intent for each provider the Respondent proposes to include in the Advanced Network and include as **Appendix B** of your response. Provide an organizational chart that depicts all participants in the Advanced Network, including the Advanced Network Lead Entity.

DSS recognizes the complexity involved, especially for independent provider organizations, to formalize agreements to join together as an MQISSP Participating Entity. A stepwise approach to the finalization of MQISSP Participating Entity provider organizations is an option for respondents to this RFP. Accordingly, Advanced Network Lead Entities are permitted to respond to this RFP prior to the finalization of formal agreements with provider organizations, so

long as the response includes a plan of how the respondent will finalize such formal agreements before the start of MQISSP.

b. Respondent's Service Delivery System

i. Describe the Respondent's service delivery system for all services provided to Medicaid beneficiaries. If the Respondent is an FQHC, describe the services the Respondent offers, the number of Connecticut Medicaid beneficiaries the Respondent serves, and the geographic area(s) served. If the Respondent is an Advanced Network Lead Entity, provide this information for both the Advanced Network Lead Entity and any other providers that will participate in the Advanced Network.

c. Governance

i. If the Respondent is an FQHC, describe what aspects of the Respondent's HRSA designation provide protection to members and lend themselves to a governance structure in support of MQISSP, including relevant description about the actual composition, mission, and activities of the FQHC's board of directors and any other relevant committees or bodies affiliated with the FQHC and how the FQHC will ensure that its governing board and/or other governing body will comply with the MQISSP requirements for a governing body detailed in Section F above.

If the Respondent is an Advanced Network Lead Entity, describe the planned composition of the oversight body, how the body will be formed (including timeframes for formation), and the planned functions and responsibilities of the oversight body, including how the Advanced Network will ensure that its governing board and/or other governing body will comply with the MQISSP requirements for a governing body detailed in Section III.F.1 above. The Advanced Network must include all applicable contracts or similar formal documents that document the relationship between the various entities within the network and must explain: (1) how these contracts and/or other documents enable the network to fulfill its mission, including coordinating care for individuals served by the network, (2) how these documents meet the requirements described in Section III.F.1 above (including, if applicable, how future and/or modified documents will meet those requirements), and (3) if applicable, how the network plans to add or change such documents and relationships in order to participate in MQISSP.

ii. Describe the Respondent's plans to ensure and promote transparency, community participation, and MQISSP Member participation in the operation of MQISSP programs and in major decisions through such methods as the Respondent deems appropriate, such as oversight body participation, a consumer advisory council, focus groups, surveys, community meetings, engagement with community partners, and/or other areas.

iii. Describe the planned role and functions of the senior leader and clinical director. Include the name of the individuals that will occupy these positions and their qualifications, as well as explaining how those qualifications will enable these individuals to implement MQISSP effectively.

d. Qualifications

i. Describe the Respondent's overall qualifications to serve as an MQISSP Participating Entity. Include a brief history of the organization, including number of years in operation, and all the strengths that the Respondent considers are an asset to the organization as an FQHC or Advanced Network Lead Entity. If the Respondent is an Advanced Network Lead Entity, also describe the strengths of any other providers that will be included in the Advanced Network.

ii. Describe the Respondent's experience participating in any shared savings arrangements with government or private payers.

e. References

i. Provide three (3) specific programmatic references for the Respondent. References shall be individuals who are able to comment on the Respondent's ability to perform the activities required by this RFP. References shall include the organization's name, and the name, a summary of the services the organization provides, and the mailing address, telephone number, and email address of a specific contact person. The reference shall be an individual familiar with the Respondent and its day-to-day performance. References cannot be the Respondent's current employees, officers, directors, or principals. If the Respondent has provided services directly or indirectly through a contract or subcontract to the State within the past three (3) years, the organization shall include a State reference. The Respondent may include a Department reference in the proposal; however, the individual named may have to refuse if s/he will be involved in the evaluation of proposals received in response to this RFP. The Respondent may also include former Department staff as references. Respondents are strongly encouraged to contact their references to ensure the accuracy of their contact information, and their willingness and ability to provide references. The Department expects to contact these references as part of the evaluation process.

References shall be able to comment on the following categories:
- Capability to implement MQISSP;
- Organizational approach; and
- Ability to problem-solve.

The reference should be able to briefly describe the Respondent's performance in each category and then rate the Respondent's performance as poor, fair, good, very good, or excellent in each category. The Department will disqualify any Respondent from competing in the RFP process if the Department discovers that the Respondent had any influence on the references.

2. Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities

A responsive proposal must include the following information about the Respondent's approach to providing Enhanced Care Coordination Activities described in this RFP. The Respondent should not simply repeat the RFP requirements.

a. Experience

i. Describe the Respondent's relevant experience in implementing care coordination for Medicaid or similar populations, including the types of care coordination interventions utilized, typical member engagement levels, and a description of the outcomes the Respondent has achieved. If the Respondent is an Advanced Network Lead Entity, provide this information for all providers participating in the Advanced Network who provide care coordination.

b. Planned Approach

i. Describe how the Respondent will support and protect the current, successful PCMH program in Connecticut Medicaid. Include how the Respondent will identify potential risks to the current PCMH program, both internal and external to the Respondent, and describe how the Respondent will monitor for and mitigate those risks. For Advanced Networks, describe each PCMH that is included in the network and its relationship with the network. If the Advanced Network includes any primary care practice that is not a DSS PCMH practice, describe how the network will comply with the requirements in Section III.F.1.a.ii above regarding the plans to enable that practice to become a PCMH within the specified timeframes.

ii. Describe how the Respondent will support the integration of behavioral health services and supports into existing operations.

iii. For each of the required Enhanced Care Coordination Activities listed in section III.F.3 above, describe the Respondent's plan for implementing the Enhanced Care Coordination Activity in order to improve the quality of care and member experience. Include specific details regarding the hiring, qualifications and training of the behavioral health care coordinator position, and the how the Respondent plans to implement the general care coordinator requirements.

iv. FQHCs: For each of the Care Coordination Add-On Activities listed in section III.F.4 above, describe the Respondent's plan for implementing these required activities. Include specific details regarding the types of staff who function as the interdisciplinary team (with special focus on the behavioral care coordinator role), the frequency of interdisciplinary team meetings, and the content of these meetings.

c. Community Linkages

i. Describe any existing partnerships between the Respondent and community-based organizations, behavioral health organizations, child-serving organizations, peer support services and networks, social services agencies, the criminal justice system, public health entities, specialists, and hospitals (with additional descriptions in cases where the Advanced Network does not already include these entities), and other State and local programs, both medical and non-medical.

ii. Describe the Respondent's plan to form new or enhanced linkages with these types of organizations under MQISSP, including the name of any specific intended partner and the nature and purpose of the partnership. Include information on when these linkages/partnerships began and nature of the partnership. In the response, highlight plans for linkages/partnerships with behavioral health and substance use organizations.

(1) Describe the expected impact of these partnerships on key outcomes related to MQISSP.
(2) Describe the Respondent's approach to leveraging these partnerships to ameliorate social determinants of health issues within the Medicaid population. Include any internal penetration rate goals and methods utilized to track if members are effectively linked to needed resources and any health outcomes monitored by the Respondent.

3. Quality

A responsive proposal must include the following information about the Respondent's approach to improving quality of care. The Respondent should not simply repeat the RFP requirements.

a. Experience

i. Summarize the Respondent's experience (and, if the Respondent is an Advanced Network Lead Entity, the experience of any other provider in the Advanced Network) implementing quality improvement initiatives. Describe key initiatives, including the goal of the initiative, the target population, and the outcomes achieved. Include detailed information on the types of reporting the Respondent utilizes to monitor their practice and track quality initiative outcomes.

b. Quality Program

i. Describe the Respondent's current quality program(s) including annual goals and/or annual quality work plan. Ensure the quality program includes specific information regarding the PCMH recognized practices and their quality program and how they support any larger organization quality programs. Describe the quality model(s) utilized, the quality program's structure, names and purpose of quality committees along with committee membership, and describe all quality reporting conducted by the Respondent with reporting frequencies. Describe the Respondent's quality improvement process and provide the staffing chart for the quality program if applicable or outline the staff and credentials with quality and performance improvement responsibilities. Include staff with responsibilities for maintaining the Respondent's Patient-Centered Medical Home recognition from NCQA or Primary Care Medical Home certification from The Joint Commission, as applicable to the Respondent.

c. Planned Approach

i. Describe the processes the Respondent anticipates implementing to monitor and improve the quality of care provided to MQISSP Members.

ii. Describe the processes the Respondent anticipates implementing to monitor, prevent, and address under-utilization of clinically appropriate services. Further, explain how the Respondent's approach ties to the Respondent's quality initiatives and to improve member care.

iii. Describe processes the Respondent anticipates implementing to identify and prevent panel manipulation.

iv. Describe how the Respondent will maximize opportunities for patient engagement in the MQISSP care coordination activities to improve health outcomes.

4. Community and Clinical Integration Program

a. Please complete the CCIP form (found in Attachment D of this RFP) and include the response as **Appendix C** of your response.

5. Data and Reporting

a. Describe the types of reporting the Respondent is currently capable of producing related to the requirements within this RFP.

6. Shared Savings Distribution

A responsive proposal must include the following information about the Respondent's plans for distributing shared savings.

a. If the Respondent is an Advanced Network Lead Entity, describe the manner in which the Respondent will distribute potential shared savings payments among providers in the Advanced Network. If the Respondent is an FQHC, describe the manner in which the Respondent will distribute potential shared savings payments within the FQHC (including, but not limited to, any payments to practitioners affiliated with the FQHC).
b. Explain how the shared savings distribution methodology ensures that there is no factor within the methodology that would reward a provider for specific contributions to the overall savings of the network.
c. Describe how the Respondent will ensure that its means of allocating shared savings supports beneficiaries in receiving appropriate services, as evidenced by individual and aggregate quality measures and measures of satisfaction.
d. Describe how the Respondent plans to safeguard against, monitor for and remedy unintended consequences associated with its means of allocating shared savings, including, but not limited to, under-service, denial of service, and steering or actual transfer of patients within or outside its network.

7. Financial Requirements

A responsive proposal must include the following information about the Respondent's fiscal stability, accounting and financial reporting systems, and relevant business practices.

a. Accounting/Financial Reporting

   i. Provide assurance that the Respondent will comply with all Department accounting and financial reporting requirements.

b. Audited Financial Statements

   i. Submit one copy each of the Respondent's three most recent annual financial statements prepared by an independent Certified Public Accountant, and reviewed or audited in accordance with Generally Accepted Accounting Principles. The copies shall include all applicable financial statements, auditor's reports, management letters, and any corresponding reissued components. Audited financial statements do not count toward the total page limit of the proposal. One copy only shall be included with the original proposal in Section V, Proposal Outline F.7.b.

      The Department reserves the right to reject the proposal of any Respondent that is not financially viable based on the assessment of the annual financial statements.

V. PROPOSAL OUTLINE

- **A. COVER SHEET**
- **B. TABLE OF CONTENTS**
- **C. CLAIM OF EXEMPTION FROM DISCLOSURE**
- **D. CONFLICT OF INTEREST — DISCLOSURE STATEMENT**
- **E. EXECUTIVE SUMMARY**
- **F. MAIN PROPOSAL**

1. **Organization**
   a. Overview
   b. Respondent's Service Delivery System
   c. Governance
   d. Qualifications
   e. References
2. **Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities**
   a. Experience
   b. Planned Approach
   c. Community Linkages
3. **Quality**
   a. Experience
   b. Quality Program
   c. Planned Approach
4. **Community and Clinical Integration Program**
5. **Data and Reporting**
6. **Shared Savings Distribution**

7. **Financial Requirements**

   a. Accounting/Financial Reporting

   b. Audited Financial Statements

- **G. APPENDICES**

  1. **A – Advanced Network Provider Form**

  2. **B –Letter(s) of Intent**

  3. **C – CCIP Form**

- **H. FORMS**

  1. **Department**

     a. Addendum Acknowledgement(s)

     b. Certification Regarding Lobbying

  2. **Other**

     a. Notification to Bidders, Parts I – V (CHRO)

     b. Consulting Agreement Affidavit (OPM Ethics Form 5) [2]

[2] Required when the contract resulting from this RFP has an anticipated value of $50,000 or more in a calendar or fiscal year; the Respondent must submit this certification to the Department with the proposal.

V. ATTACHMENTS

A. MQISSP QUALITY MEASURE SET

MQISSP Quality Measure Set

MQISSP Measure Number	Quality Measure Title	Measure Steward	National Quality Foundation #
1	Adolescent well-care visits	NCQA	NA
6	Avoidance of antibiotic treatment in adults with acute bronchitis	NCQA	0058
11	Developmental screening in the first three years of life	OHSU	1448
13	Diabetes HbA1c Screening	NCQA	0057
15	Emergency Department (ED) Usage	NCQA	NA
19	Medication management for people with asthma	NCQA	1799
25	Prenatal care and Postpartum care	NCQA	1517
27	Well-child visits in the first 15 months of life	NCQA	1392

MQISSP Measure Number	Challenge Measure Title	Measure Steward	National Quality Foundation #
7	Behavioral Health Screening 1–17	NCQA	NA
20	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	NA
22	PCMH CAHPS	AHRQ	NA
23	Readmissions within 30 Days	MMDN	NA
24	Post-Hospital Admission Follow up	DSS	NA

MQISSP Measure Number	Reporting Only Measure Title	Measure Steward	National Quality Foundation #
2	Annual fluoride treatment ages 0<4	DSS	NA
3	Annual monitoring for persistent medications (roll-up)	NCQA	2371
4	Appropriate treatment for children with upper respiratory infection	HEDIS	69
5	Asthma Medication Ratio	HEDIS	1800
8	Breast cancer screening	NCQA	2372
9	Cervical cancer screening	NCQA	0032
10	Chlamydia screening in women	NCQA	0033
12	Diabetes eye exam	NCQA	0055
14	Diabetes: medical attention for nephropathy	NCQA	0062
16	Follow-up care for children prescribed ADHD medication	NCQA	0108
17	Frequency of Ongoing Prenatal Care[1]	NCQA	1391
18	Human Papillomavirus Vaccine (HPV) for Female Adolescents	NCQA	1959
21	Oral evaluation, dental services	ADA	2517
26	Use of imaging studies for low back pain	NCQA	0052
28	Well-child visits in the third, fourth, fifth and sixth years of life	NCQA	1516

Notes:
1. This quality measure will be removed from the list of Reporting Only quality measures and will not be tracked as part of the MQISSP.

Definitions:
- **ADA**: American Dental Association
- **AHRQ**: Agency for Healthcare Research and Quality
- **DSS**: Department of Social Services
- **HEDIS**: Healthcare Effectiveness Data and Information Set
- **MMDN**: Medicaid Medical Directors Network
- **NA**: Not Applicable
- **NCQA**: National Committee for Quality Assurance
- **OHSU**: Oregon Health & Science University

MQISSP Quality Measure Set

Scoring Measures	Measure Steward	National Quality Foundation #
Adolescent well-care visits	NCQA	NA
Avoidance of antibiotic treatment in adults with acute bronchitis	NCQA	0058
Developmental screening in the first three years of life	OHSU	1448
Diabetes HbA1c Screening	NCQA	0057
Emergency Department (ED) Usage	NCQA	NA
Medication management for people with asthma	NCQA	1799
PCMH CAHPS	AHRQ	NA
Prenatal care and Postpartum care	NCQA	1517
Well-child visits in the first 15 months of life	NCQA	1392

Challenge Measures	Measure Steward	National Quality Foundation #
Behavioral Health Screening 1–17	DSS	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	NA
Readmissions within 30 Days	MMDN	NA
Post-Hospital Admission Follow up	DSS	NA

Reporting Only Measures	Measure Steward	National Quality Foundation #
Annual fluoride treatment ages 0<4	DSS	NA
Annual monitoring for persistent medications (roll-up)	NCQA	2371
Appropriate treatment for children with upper respiratory infection	NCQA	0069
Asthma Medication Ratio	NCQA	1800
Breast cancer screening	NCQA	2372
Cervical cancer screening	NCQA	0032
Chlamydia screening in women	NCQA	0033
Diabetes eye exam	NCQA	0055
Diabetes: medical attention for nephropathy	NCQA	0062
Follow-up care for children prescribed ADHD medication	NCQA	0108
Human Papillomavirus Vaccine (HPV) for Female Adolescents	NCQA	1959
Oral evaluation, dental services	ADA	2517
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Definitions:
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- **NCQA**: National Committee for Quality Assurance
- **OHSU**: Oregon Health & Science University

B. CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

OMH U.S. Department of Health and Human Services Office of Minority Health

www.ThinkCulturalHealth.hhs.gov

THINK CULTURAL HEALTH

The Case for the Enhanced National CLAS Standards

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.
— Dr. Martin Luther King, Jr.

Health equity is the attainment of the highest level of health for all people (U.S. Department of Health and Human Services [HHS] Office of Minority Health, 2011). Currently, individuals across the United States from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age (World Health Organization, 2012), such as socioeconomic status, education level, and the availability of health services (HHS Office of Disease Prevention and Health Promotion, 2010). Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals.

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern. In the United States, it has been estimated that the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care is $1.24 trillion (LaVeist, Gaskin, & Richard, 2009). Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services (Beach et al., 2004; Goode, Dunne, & Bronheim, 2006). By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards will improve an organization's ability to address health care disparities.

The enhanced National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2011) and the National Stakeholder Strategy for Achieving Health Equity (HHS National Partnership for Action to End Health Disparities, 2011), which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country. Similar to these initiatives, the enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States.

Bibliography:

Beach, M. C., Cooper, L. A., Robinson, K. A., Price, E. G., Gary, T. L., Jenckes, M. W., Powe, N.R. (2004). Strategies for improving minority healthcare quality. (AHRQ Publication No. 04-E008-02). Retrieved from the Agency of Healthcare Research and Quality website: http://www.ahrq.gov/downloads/pub/evidence/pdf/minqual/minqual.pdf

Goode, T. D., Dunne, M. C., & Bronheim, S. M. (2006). The evidence base for cultural and linguistic competency in health care. (Commonwealth Fund Publication No. 962). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf

LaVeist, T. A., Gaskin, D. J., & Richard, P. (2009). The economic burden of health inequalities in the United States. Retrieved from the Joint Center for Political and Economic Studies website: http://www.jointcenter.org/sites/default/files/upload/research/files/The%20Economic%20Burden%20of%20Health%20Inequalities%20in%20the%20United%20States.pdf

National Partnership for Action to End Health Disparities. (2011). National stakeholder strategy for achieving health equity. Retrieved from U.S. Department of Health and Human Services, Office of Minority Health website: http://www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=338ID=286

U.S. Department of Health and Human Services. (2011). HHS action plan to reduce racial and ethnic health disparities: A nation free of disparities in health and health care. Retrieved from http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). Healthy people 2020: Social determinants of health. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39

U.S. Department of Health and Human Services, Office of Minority Health (2011). National Partnership for Action to End Health Disparities. Retrieved from http://minorityhealth.hhs.gov/npa

World Health Organization. (2012). Social determinants of health. Retrieved from http://www.who.int/social_determinants/en/

OMH U.S. Department of Health and Human Services Office of Minority Health

www.ThinkCulturalHealth.hhs.gov

THINK CULTURAL HEALTH

■ C. RESPONSE as APPENDIX A: ADVANCED NETWORK PROVIDER FORM

Name of Advanced Network Lead Entity: _____

Respondents that are Advanced Network Lead Entities are required to complete the table below. Please include information on all providers/provider practices that will participate in the Advanced Network. For each provider/provider practice, include the name of the provider/provider practice, the provider/provider practice's national provider ID (NPI), provider/provider practice's primary address, whether the provider/provider practice is a DSS PCMH, and whether the provider/provider practice is an independent entity or an affiliate, subsidiary, or division of another entity.

Using the format provided below, complete this information for as many provider entities as are necessary to describe the provider entities within the Advanced Network that are part of the Respondent's proposal to participate in MQISSP. If any information on this table does not correspond to the organizational chart, please explain any differences and/or where various providers on this table fit within the organizational chart.

Provider/Provider Practice Name	NPI	Primary Business Location (City, Zip)	Specialty (e.g., primary care, behavioral health, cardiology, etc.)	DSS PCMH (Y/N)	Business Type (e.g., independent entity, affiliate, subsidiary, or division of another entity)

■ D. RESPONSE as APPENDIX C: CCIP FORM

Respondents other than those who are participating in the CMMI Practice Transformation Network (PTN) grant program (Funding Opportunity Number CMS-1L1-15-003, CFDA 93.638) are required to complete the following information related to the Clinical and Community Integration Program (CCIP).

☐ Respondent is participating in the PTN Grant Program – please do not complete the below questions.

1. MQISSP Participating Entities have the option to participate in Track 1 or Track 2 of CCIP, as detailed on (insert page number on which the above chart appears). Check the applicable box:

   ☐ Respondent will participate in Track 1

   ☐ Respondent will participate in Track 2

2. CCIP is comprised of three core standards (Comprehensive Care Management, Health Equity Improvement, and Behavioral Health Integration) and three elective standards (Oral Health Integration; E-Consults; Comprehensive Medication Management). Please indicate by check mark below if the Respondent is requesting technical assistance in support of any or all of the three elective standards:
   ☐ Oral Health Integration
   ☐ E-Consults
   ☐ Comprehensive Medication Management

3. The CCIP initiative depends on committed leadership, a team of key personnel, and change management activities to ensure the success of care delivery reforms. Please describe your organization's proposed approach to the following:

   a. What type of leadership and team do you plan to establish to help your organization meet CCIP change process philosophy, such as personnel, titles, and qualifications; what time does your organization foresee allocating to this effort?

   b. What management and accountability do you see best helping develop CCIP capabilities, such as achieving the goals and milestones established in the Transformation Plan?

   c. How does your organization foresee most effectively collaborating with the CCIP transformation vendor/s;

   d. How does your organization propose to provide quality improvement expertise and support with regard to operational, financial and business process redesign and broad quality improvement related to CCIP capabilities; and

   e. How does your organization plan to provide clinical guidance, expertise, and support within the organization and among affiliated practices to support dissemination.

4. Respondent: please describe your current care delivery reform and quality improvement efforts and detail how these will be integrated with and support the development of CCIP capabilities?

5. Respondent: please describe how you plan to engage clinicians/practices in meeting CCIP standards?

6. The CCIP standards are intended to improve care for all beneficiaries, including those insured by Medicare, Medicaid, CHIP, and commercial insurers. Respondent - please affirm your commitment to achieving these standards and improving care for all populations, regardless of payer.