

Connecticut Health Insurance Exchange

Exchange Call Center

Request for Proposal

October 5, 2012

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1. INFORMATION

1.1. Authorized Contact Person

The Authorized Contact Person for all matters concerning this Request for Proposal (RFP) is:

Name:	Margo Lachowicz
Title:	Connecticut Health Insurance Exchange Project Assistant
Mailing Address:	Connecticut Health Insurance Exchange, 450 Capitol Avenue MS# 52HIE, Hartford, CT 06106-1379
E-Mail Address:	CTHIX.CallCenterRFP@ct.gov
Phone:	(860) 418-6285

All questions to, and requests for information from the Connecticut Health Insurance Exchange concerning this RFP by a Prospective Responder or a Responder, or a representative or agent of a Prospective Responder or Responder, should be directed only to the Authorized Contact Person. Include "Exchange Call Center RFP" in all correspondence.

Questions should be made in writing, and submitted by email. All answers to questions, and any Addenda to this RFP, will be made available to all Prospective Responders.

1.2. Release Date of this RFP

October 5, 2012

1.3. Intention to Propose

Each Responder must indicate their intention to propose by signing (by an authorized representative) and returning a copy of an Intention to Propose form (see Appendix C) by the close of business (5:00PM ET) on **October 10, 2012**. The form should be emailed to the Authorized Contact Person, as identified in Section 1.1: Authorized Contact Person.

1.4. Proposal Due Date, Time, and Location

Date:	November 5, 2012
Time:	5:00 PM ET
Location:	Connecticut Health Insurance Exchange, 450 Capitol Avenue MS# 52HIE, Hartford, CT 06106-1379
Attn:	Margo Lachowicz

Proposals in the format required by this RFP must be received by the Exchange at the above location, by the date and time prescribed above. The Exchange will consider requests made to the Authorized Contact Person to extend the Proposal Due Date and Time specified above. However, unless the Exchange issues a written addendum to this RFP which extends the Proposal Due Date and Time for all Responders, the Proposal Due Date and Time specified above shall remain in effect. Emailed or faxed proposals will not be accepted by the Exchange.

The Exchange bears no responsibility for the cost of preparing a response to this solicitation. Proposals received at this location after the Proposal Due Date and Time are considered late and shall not be accepted by the Exchange.

1.5. Anticipated Contract Start Date

April 1, 2013

2. BACKGROUND

2.1. Scope of Solicitation

2.1.1. Introduction/Overview

The Connecticut Health Insurance Exchange (Exchange) is issuing this RFP to qualified Call Center Vendors for the Exchange solution that will support the State of Connecticut's human services programs in the future. This RFP seeks proposals from Call Center Vendors with business process outsourcing (BPO) solutions that provide customer support for the Exchange and Integrated Eligibility (IE) solutions to establish the Exchange Call Center and a supporting Interactive Voice Response (IVR) system.

As an initial step in the evolution of human services delivery within the State, Connecticut has agreed to pursue a single IE system to be used to establish eligibility for all human services programs including Medicaid, Children's Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and for subsidized healthcare insurance provided by the Exchange.

In 2011, an estimated 365,000 Connecticut residents lacked health coverage. Via the Affordable Care Act (ACA), many of these residents will likely be eligible for subsidized health insurance, either through the expansion of Medicaid or through the Exchange. Starting in late 2013, individuals will be able to supply a limited amount of information to the Exchange and determine whether they are eligible for coverage under any of the State's publicly-subsidized health coverage programs.

To facilitate eligibility determinations, the ACA requires each Exchange to operate a toll-free telephone number to provide access to individuals and employers seeking support with a variety of Exchange-related functions, including consumer support programs, Advance Premium Tax Credits (APTC), Cost-Sharing Reductions (CSR), eligibility, the applications process, information on Qualified Health Plans (QHP), etc. via a direct Exchange Call Center and/or IVR support.

As such, it has been determined that the new Exchange Call Center is required to be operational in support of Medicaid expansion and the Health Insurance Exchange by October 1st, 2013 for Connecticut to meet the ACA deadlines. While the ACA requires states to provide a toll-free number and customer service functionality to be operational by October 1st 2013, the Exchange is considering launching Exchange Call Center functionality and publicizing the toll-free number in advance of this date on September 1, 2013 to respond to preliminary customer information requests.

It is the Exchange's desire to have a single 1-800 number for the Exchange to enhance the ability of consumers to reach the requested services in the most efficient manner possible. The Exchange Call Center and supporting IVR system must also be accessible to individuals with disabilities and those with limited proficiency in English, and the contact number must be prominently displayed on the Exchange website. In addition to the Exchange website, the Exchange Call Center will provide entrance significant channel into the Exchange and will be utilized (in conjunction with the website) for a significant portion of the consumers. These consumers will be provided the opportunity to make basic inquiries regarding the Exchange, plan options and costs, eligibility in public health programs, and enrollment in the Exchange. While consumers will be steered to the website for self-service whenever possible, the consumer support offered through the Exchange Call Center will

provide full service to those consumers that need it. Additional requirements are highlighted in the next sections of this document.

2.1.2. Consumer Support Components

Figure 1 below presents an overview of the Exchange Consumer Support system, anticipated communication channels, and high-level business functions that will be supported by the Exchange. Those that are applicable to Exchange Call Center and supporting IVR system are highlighted in red.

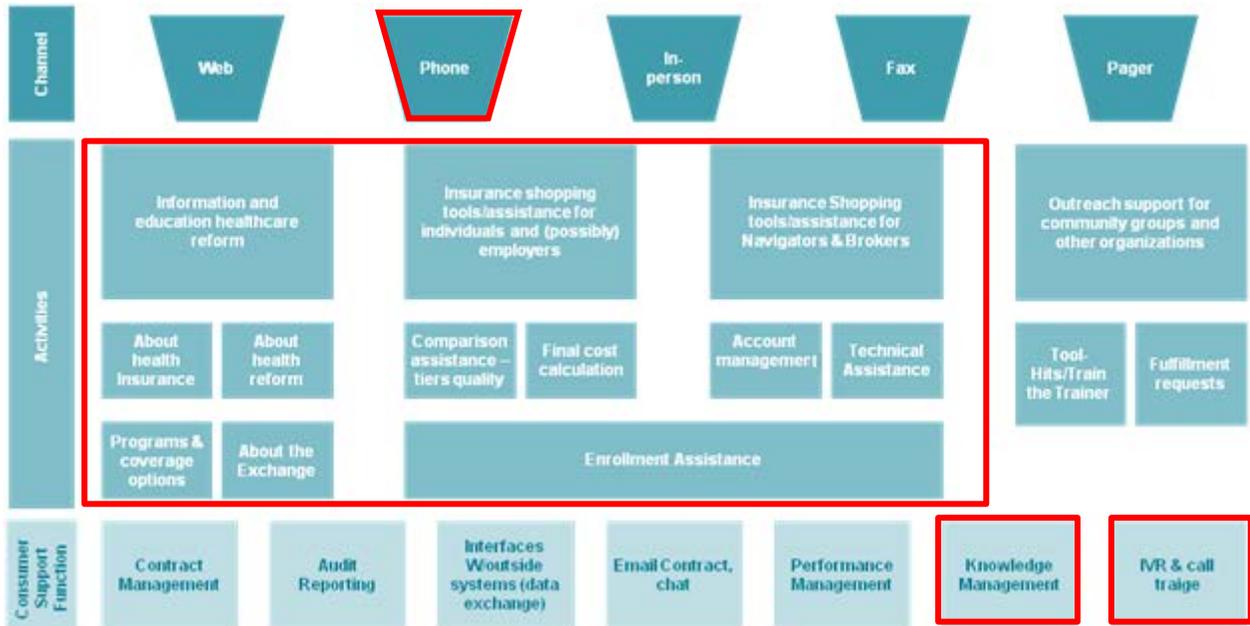


Figure 1: Exchange/IE Consumer Support System Components

As part of this RFP, the Exchange is seeking for a Call Center Vendor for Tier 1 and Tier 2 consumer support. Tier 0 and Tier 3 consumer support descriptions provided below are for reference purposes only and are not within the scope of this solicitation.

- Tier 0 Self Service** – Provides website functionality, ability to file a complaint, fill out an application, etc. Resources are available 24 hours a day, seven days a week and can be accessed prior to contacting the Exchange Call Center. Functionality is two-fold, with online education materials, tables, references, etc., and the ability to submit information request, eligibility applications, or complaints via the website. *Please note, that website (Tier 0 Self Service) consumer assistance function will work in conjunction with the Exchange Call Center and will be developed by the State’s System Integrator. The Call Center Vendor is expected to utilize the Tier 0 Self Service functionality as a means to route simple consumer inquiries to the website.*
- Tier 1 Exchange Call Center** – The highest or first contact for consumers. Tier 1 Exchange Call Center personnel provide triage function to direct consumers to additional sources of information or services to meet their needs. Calls are answered by an IVR, or a person, who can direct calls to the appropriate entity for resolution, or provide basic answers via existing knowledge, business rules or process rules. Services offered in this tier include answering questions about the Exchange and health care reform, directing existing Medicaid consumers to DSS Benefits Center via IVR prompts or a “warm transfer”, as well as routing and resolving complaints and appeals to the appropriate State agencies such as the Connecticut Insurance Department (CID) and Office of the Healthcare Advocate (OHA) via a “cold transfer”. Program changes or requests for action from consumers such as re-enrollment and eligibility will generate

call activity. If the consumer knows what QHP they would like to enroll or re-enroll, the Exchange Call Center will be able to provide such support, as well as assist with account management. Note that if the consumer is uncertain as to which QHP they are eligible for, the consumer will be directed to Tier 2 Exchange Call Center support. Some technical issues may be directed to Tier 3 as appropriate.

- **Tier 2 Exchange Call Center** – Tier 2 Exchange Call Center personnel has specific knowledge about consumer issues and should be able to resolve most issues. Resolution may be immediate or may require substantial effort. In the event that eligibility and QHP enrollment services are not satisfied in Tier 1, consumers will be directed to Tier 2 Exchange Call Center personnel. If the consumer is experiencing difficulty deciding which plan that they are qualified to enroll or re-enroll in, then the Tier 2 Exchange Call Center will direct the consumer to a licensed Broker. The licensed Broker will be responsible for helping the consumer with extensive plan comparison support and consultative insurance advice. Please refer to Section 4.8: Cost/Pricing Proposal that explains scenarios regarding licensed Brokers that the Responder will need to complete. Some technical issues may be escalated to Tier 3, as appropriate.
- **Tier 3 Exchange Call Center** – Provides technical resolution or changes to business functions or IT components to rectify problems. There is no escalation above Tier 3. *Please note that this function is out of scope of the current RFP and will be provided by the internal State resources.*

2.2. Business Justification

2.2.1. Current Environment

There are currently several Call Centers supporting State-sponsored health insurance programs and consumer inquiries in Connecticut. For example, the Connecticut Department of Social Services (DSS) Benefits Center provides assistance related to individuals obtaining or maintaining health services in publicly sponsored health programs. DSS Benefits Centers handled nearly 400,000 calls in 2011. Additionally, the Connecticut Insurance Department (CID) and Office of the State Healthcare Advocate (OHA) operate smaller Call Centers that focus on consumer support for complaints and appeals. While the current Connecticut Call Centers do not provide all of the functionality necessary for an Exchange Call Center, they do provide important capabilities that can be utilized to support and supplement the services provided directly by the Exchange Call Center.

Connecticut's existing consumer assistance programs currently operate as separate organizations without the benefit of facilitated integration, each having separate 1-800 lines for their Call Centers, and the inability to allow "seamless" transfer of calls to other appropriate agencies within the State health insurance arena. Each program offers at least one main 1-800 number for access, with DSS offering additional numbers for each of their regional offices. Current programs utilize basic Customer Relationship Management (CRM) solutions and have limited automated call distribution functionality. Data management and reporting features are not highly flexible and may not be easily adaptable to the changes required under healthcare reform.

DSS is in the midst of a Modernization of Client Service Delivery Project, branded as ConneCT, which is being implemented in phases beginning in July, 2012. The ConneCT initiative's core components include a "Benefit" Center (i.e., Call Center) and IVR implementation. Service delivery capabilities are expected to improve as a result of the implementation of new Exchange Call Center functionality that supports DSS eligibility and enrollment processing for State-sponsored health insurance programs. Figure 2 below depicts the current environment.

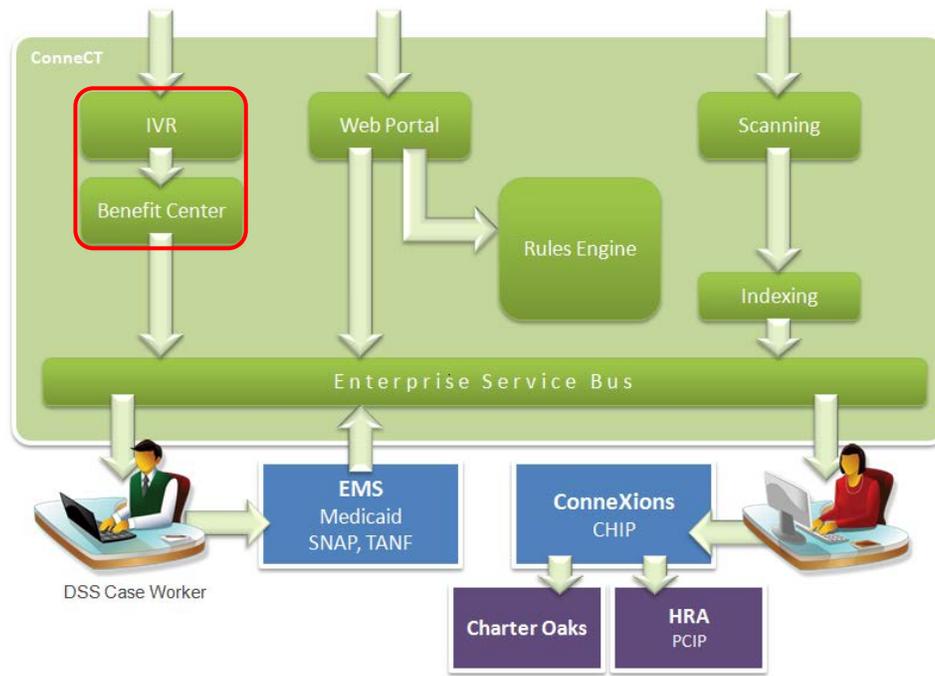


Figure 2: Current Environment

The ConneCT project scope, as currently configured, will not meet all of the needs of the Exchange Call Center. Determining how the Exchange Call Center will integrate with the DSS Benefits Center, both from an IT perspective, and from a consumer service perspective will require collaboration on the part of the Exchange, DSS, and the selected Call Center Vendor.

2.2.2. Future State

The mission of the Exchange Call Center is to maximize value to customers by providing universal health coverage eligibility determinations and QHP enrollment assistance in one location. The intent is for the Exchange Call Center to provide customers with an accessible means to receive health coverage assistance, while empowering them to make the best health coverage decision for themselves and their families.

The Exchange Call Center will provide tiered support, maximize self-help options, and utilize specialized Exchange Call Center Representatives for more complex calls, thus providing the Exchange with flexibility and technical functionality necessary to maximize efficiencies in operation and promote an integrated knowledge base. The Exchange Call Center will facilitate “cold transfer” hand-offs for consumer support complaints, appeals and inquiries that will be routed to existing consumer assistance programs such as CID, OHA, while Medicaid enrollment-related inquiries and inquiries from existing Medicaid clients will be transferred over to the DSS Benefits Center via a “warm transfer” as appropriate. Billing and collections inquiries will also be transferred to the appropriate QHP Issuers.

The Responder is asked to establish and staff an Exchange Call Center that will provide assistance to individuals, employers, employees, navigators and brokers prior to an individual’s enrollment in commercial health insurance coverage offered through the Exchange. It is expected that Exchange Call Center services provided via this procurement will include a Customer Relationship Management solution and an IVR solution. It should be noted that a majority of consumers will be assisted through the IVR or Web Portal while select consumers may need some level of support with human

interaction. This human interaction will be either through Exchange Call Center or with a Navigator or similar assistance organization. In addition, licensed insurance brokers will be able to assist with selecting a plan for consumers who have yet to make a decision to enroll in a specific plan. Please refer to the pricing table in Section 4.8: Cost/Pricing Proposal for scenarios regarding licensed Brokers that the Responder will need to complete.

The Exchange Call Center will perform activities necessary to receive, log, and track incoming communications. The system functionality required to support the Exchange Call Center function is provided in more detail in Appendix B: Requirements Traceability Matrix. Figure 3 below depicts the desired future state.

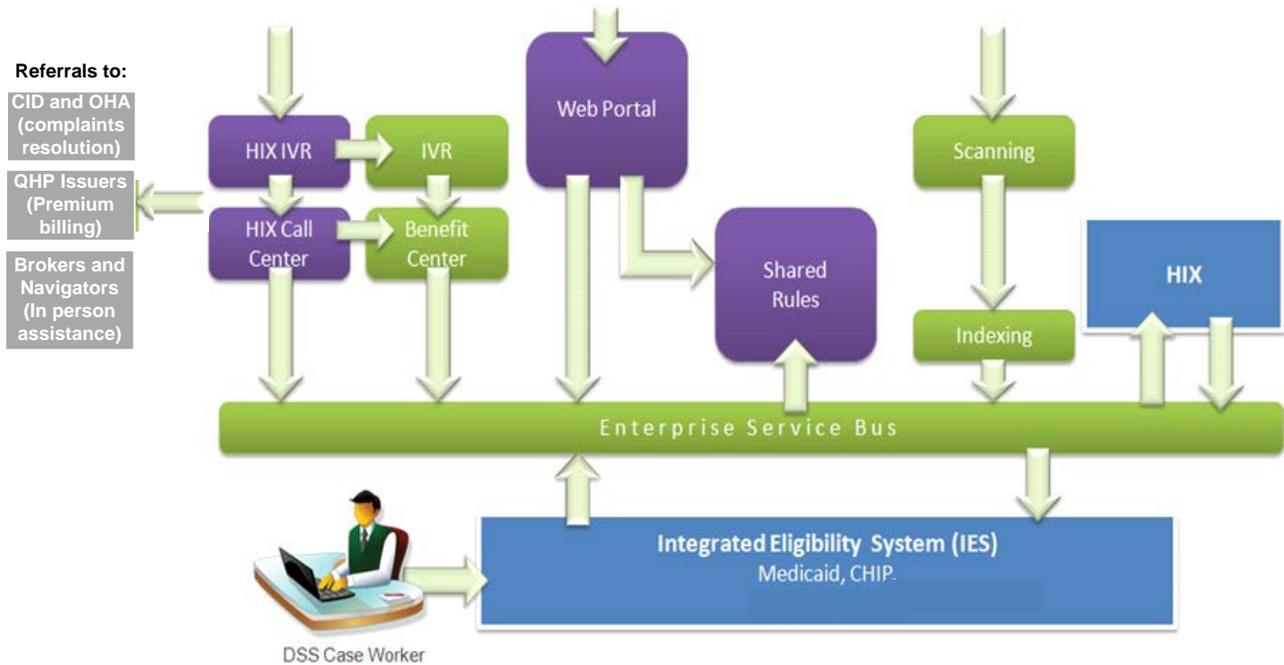


Figure 3: Future Environment

2.2.3. Volumetrics

The Exchange Call Center must be robust enough to handle the expected population with the flexibility to adjust to varying usage rates (see Table 3 Consumer Support Interaction Scenarios). This RFP is requesting a Vendor to stand-up an adequately sized and resourced Exchange Call Center operation supported by an IVR system to meet the Exchange volume and support service needs during the Exchange open enrollment and steady state operations. Section 155.410 of the ACA defines initial and annual open enrollment periods as depicted on Figure 4.

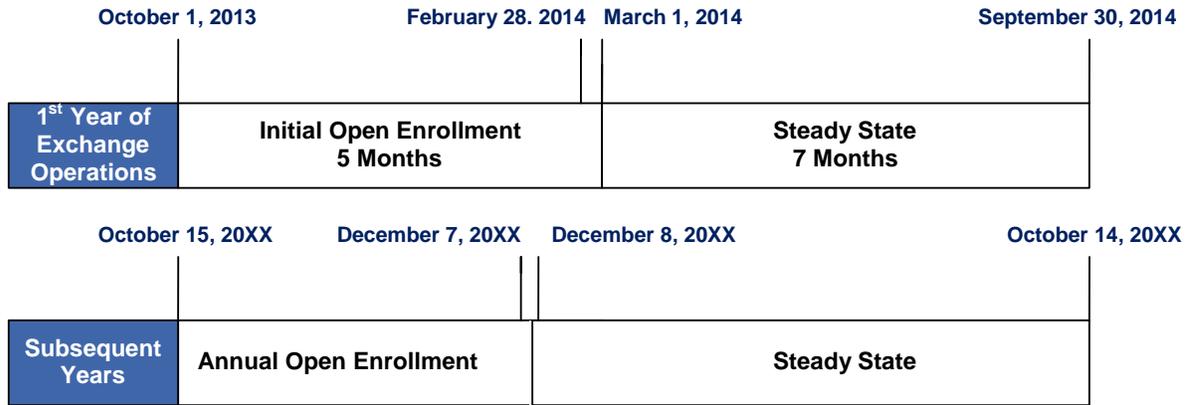


Figure 4: Enrollment Periods

Table 1 and 2 provide the estimates for a baseline consumer population estimate for the initial Exchange operations starting third quarter of 2013 (open enrollment) as well as a steady state of Exchange operations. The Exchange projects a much larger influx of daily consumer response in the first few months of open enrollment following the Exchange’s commenced operations, and a substantial drop off thereafter. Please note that total population estimates below represent the anticipated consumer universe (Table 1 and Table 2).

Table 1 – Estimated Exchange User Population - Open Enrollment

Population	Description/Source	Total Population
Open Enrollment Exchange	This population represents an initial influx of consumers applying through the Exchange to enroll in a Qualified Health Plan.	103,500
DSS Medicaid Newly Eligible Population	This population is reflective of Medicaid expansion and will cover childless adults up to 138% of the Federal Poverty Level (FPL). The Exchange will serve as a front door to determine their MAGI eligibility, and DSS Benefits Center will enroll these individuals in the public health insurance programs.	155,700
Low-income Children Population	Low-income children between 139% and 200% of the FPL that would qualify for HUSKY B will apply through the Exchange (portal or Exchange Call Center). The Exchange will determine their eligibility under new Modified Adjusted Gross Income (MAGI) rules and then refer them out to DSS Benefits Center for enrollment.	3,500
Total Estimated Exchange User Population – Open Enrollment		262,700

Table 2 – Estimated Exchange User Population – Steady State

Population	Description/Source	Total Population
Steady State Exchange	This population represents consumers applying through the Exchange to enroll in a Qualified Health Plan after initial open enrollment period.	155,250
Current Medicaid Population	This population represents current Medicaid population that may use the Exchange to re-determine their MAGI eligibility or report change in circumstances that may cause MAGI eligibility re-determination. It is expected that the majority of this	616,655

Population	Description/Source	Total Population
	population will be able to renew their benefits automatically.	
Medicaid newly eligible population (including low income children)	This population is reflective of Medicaid expansion. After the open enrollment period, these consumers will use the Exchange to determine their eligibility or report change in circumstances.	159,200
Total Estimated Exchange User Population – Steady State		931,105

The anticipated membership’s potential usage of various consumer outreach channels is based on the degree of human intervention required to address the query. The four major types of interaction listed by extent of Exchange Call Center resources required include:

- **Tier 0 Self Service (Web Portal/Individual Never Calls/Individual Assisted by Brokers/Navigators)** – individual either does not call in, or individual inquiries can be directed to the Web, or individual can utilize either a Broker or a Navigator to resolve their inquiries. It is expected that some consumers will be able to receive the required level of support through Tier 0 self service functionality of the Exchange web portal without direct contact with the Exchange Call Center personnel.
- **Tier 1 Exchange Call Center (Simple Inquiry or IVR)** – calls that relate to simple consumer inquiries and that can be resolved within the first three minutes.
- **Tier 1 and Tier 2 Exchange Call Center (MAGI Eligibility Support)** – calls that would require assisting the individuals to determine their eligibility.
- **Tier 1 and Tier 2 Exchange Call Center (Exchange Plan Enrollment)** – calls from consumers who are eligible for a QHP and need assistance to enroll in a QHP plan.

Two scenarios described below define anticipated usage percentages of the four interaction types and illustrate assumptions how various applicants will interact with the customer support functions for support by scenario:

- **Scenario 1 (Moderate Automated Interaction)** – involves an even distribution of calls between those requiring higher CSR interaction (i.e., eligibility and enrollment) and those requiring less interaction (i.e., simple questions and web directed).
- **Scenario 2 (Highly Automated Interaction)** – involves a greater percentage of calls that require less CSR interaction and can be handled via the self service automated channels (i.e., web, IVR) or through third party assisters (Brokers/Navigators) with the use of web portal.

The shaded portion of the Table 3 below represents possible consumer influx that the Exchange Call Center may experience when it is operational. The Exchange has no historical data on call arrival pattern or the expected variations in volume of calls over the month and over the year. The State expects the Responder to have the necessary expertise to properly anticipate load and staffing requirements for the Exchange Call Center.

Table 3 – Consumer Support Interaction Scenarios (by population percentage)

Scenario	Tier 0 Self Service (Web Portal)/ Assisted by Brokers/Navigators	Tier 1 Exchange Call Center (Simple Inquiry or IVR support)	Tier 1 and Tier 2 Exchange Call Center (MAGI Eligibility Support)	Tier 1 and Tier 2 Exchange Call Center (QHP Plan Enrollment)	Total Population
Scenario 1 (Moderate Automated Interaction)	25%	25%	25%	25%	100%
Scenario 2 (Highly Automated Interaction)	40%	30%	20%	10%	100%

The Exchange will make every effort to influence potential applicants to use the more automated consumer support channels (e.g., IVR, web) through its various campaigns, training and outreach efforts. Note that the degree of Web utilization will depend significantly upon ease of use for consumers and how simple the shopping and enrollment processes are to navigate. The Responder should therefore consider both scenarios in replying to this proposal.

2.2.4. Exchange Call Center Design Goals

While building an Exchange requires work across a diverse spectrum of functions and disciplines, the State continues to make sure that all activity is aligned to 5 simple goals for the organization:

1. Create an easy and simple consumer experience for shopping and comparison of insurance options
2. Promote innovation and new options for benefit coverage in the State
3. Provide empathetic and responsive customer service
4. Work with the Exchange’s health plans, brokers, and navigators to provide more affordable products and broad distribution support
5. Launch a substantive and targeted communications and outreach campaign that promotes awareness of health reform and new options for consumers and small businesses in the State

Implementing the Exchange Call Center and meeting the above-stated objectives will bring a number of benefits to the State of Connecticut, including:

2.2.4.1. Simplified Citizen Access

- Provide multichannel access into the State including Web, IVR, and Web-chat through a “no wrong door” approach for a seamless consumer assistance experience.
- Institute a new, Exchange specific 1-800 number for consumers to receive required assistance over the phone.
- Expand Exchange Call Center hours of operation to 8 am-8pm ET Monday through Friday so that individuals have greater opportunity to access Exchange Call Center services.

2.2.4.2. Seamless and Efficient Exchange Call Center Operations

- Provide access to an up-to-date and integrated client record across all programs at each touch point.
- Flexibly align eligibility processes to the needs and preferences of clients and front-line workers.
- Improve quality (completeness, relevance, timeliness, accuracy) of data collected and used for eligibility.

2.2.4.3. Consumer Channel Integration

- Leverage the existing expertise of current consumer assistance programs, while still providing an overarching “no wrong door” approach toward customer service.
- Triage consumer needs and direct them to existing programs or to new assistance resources developed by or promoted through the Exchange as appropriate. Given their statutory mandates agencies such as CID, OHA, and DSS will continue to provide services to consumers seeking insurance coverage and experiencing difficulties.
- Clearly identify parameters of service for each entity, and develop standards for referrals to other entities to develop a collaborative and cooperative consumer assistance experience.

2.2.4.4. Capacity and Scalability

- Scale the Exchange Call Center resource pool to client demands (e.g., provide the capability to quickly provide dedicated resources to meet immediate and long-term growth, namely between open enrollment and steady state periods).

2.2.4.5. Financial Benefits

- Use CRM technology to manage incidents, problems, knowledge and change management processes across all stakeholder groups’ enables end-to-end management of issues affecting the consumer community.
- Consolidation of service demand with one Call Center Vendor to enable additional efficiencies and reduced revenue risk for that Vendor.
- Use standard tools and processes to streamline Exchange Call Center activities and reduce unnecessary and redundant workflow.

2.2.4.6. Quality Metrics

- Leverage lessons learned from the Call Center Vendor’s existing client relationships in order to implement more effective service levels to drive and incentivize improvements in quality.

2.2.4.7. Knowledge Retention

- Train and retain a core Exchange Call Center personnel team who will be highly experienced and knowledgeable regarding the Exchange/IE business and user community.

2.2.4.8. Streamlined Process

- Use of standard processes and proven enabling tools to increase predictability and improve quality of Exchange Call Center services.

2.2.4.9. Innovation

- Continuously bring new ideas and methods to the relationship though introducing ways to improve Call Center Vendor methodologies and to bring value-added opportunities to the Exchange.

2.3. Project Dependencies

2.3.1. State Agency Collaboration

This project has significant impacts on the operations of all involved State agencies, including, but not limited to, the Exchange, DSS, OHA, CID, the Connecticut Bureau of Enterprise Systems and

Technology (BEST), among others. Each of the agencies will need to make changes and additions to their existing operations in order to support the ACA requirements and to facilitate an efficient and proper implementation and operation of an Exchange/IE solution. These State agencies are active participants in supporting and guiding the project.

2.3.2. Financial Sustainability

Connecticut is challenged to create a financially sustainable Exchange that is entirely self-funded post-2014. Key cost and revenue assumptions must be regularly revisited to protect the fiscal strength of the State.

2.3.3. Critical Supporting Data Interfaces

The eligibility determination process is reliant on key data interfaces from State and Federal databases and is therefore dependent upon timely availability of the key interfaces defined, developed, and tested by the State's System Integrator.

2.4. Critical Success Factors

2.4.1. Resource Commitment to the State of Connecticut

With so many states seeking to hire Call Center Vendors to support their Exchange/IE systems, there is a concern that Call Center Vendors will be overextended and will not be able to commit adequate resources to their individual State efforts. Therefore, focus will be placed on selecting a Call Center Vendor with deep experience in delivering similar citizen-centric solutions and is able to demonstrate their ability to commit the required depth and breadth of experienced resources specifically to the Connecticut project.

2.4.2. State Agency Coordination

With the compressed timeframes set forth by the Federal government, the selected Call Center Vendor should be able to demonstrate the capability to work effectively across several state agencies in Connecticut. The importance of working with numerous State agencies simultaneously is critical in meeting the deadlines of designing and implementing the Exchange Call Center for the State of Connecticut.

2.5. Assumptions

Connecticut made a number of assumptions in determining the scope for the Exchange Call Center project. In addition to assumptions outlined below, the Responder should identify any assumptions being made with respect to this service request and submit them as part of the Exchange Call Center Responder's proposal.

2.5.1. Scoping Assumptions

Critical deadlines to comply with the ACA include implementation of integrated eligibility to support Medicaid expansion and streamlined integration with the Exchange by October 2013 for clients applying for 2014 coverage. As such, our anticipated goal for Exchange Call Center operations requires go-live by no later than September 1, 2013 in order for the Exchange Call Center to be tested, modified, promoted and fully integrated into the eligibility determination process.

2.5.2. Administrative Assumptions

- The Exchange's subject matter experts and user groups will be made available to Vendor staff.
- The selected Vendor will provide weekly and monthly project status reports to the Integrated Eligibility Program Management Organization (IEPMO).

2.6. Project Organization

The organizational chart below shows the reporting relationships of key project participants. The selected Call Center Vendor will report to the IEPMO on a periodic basis.

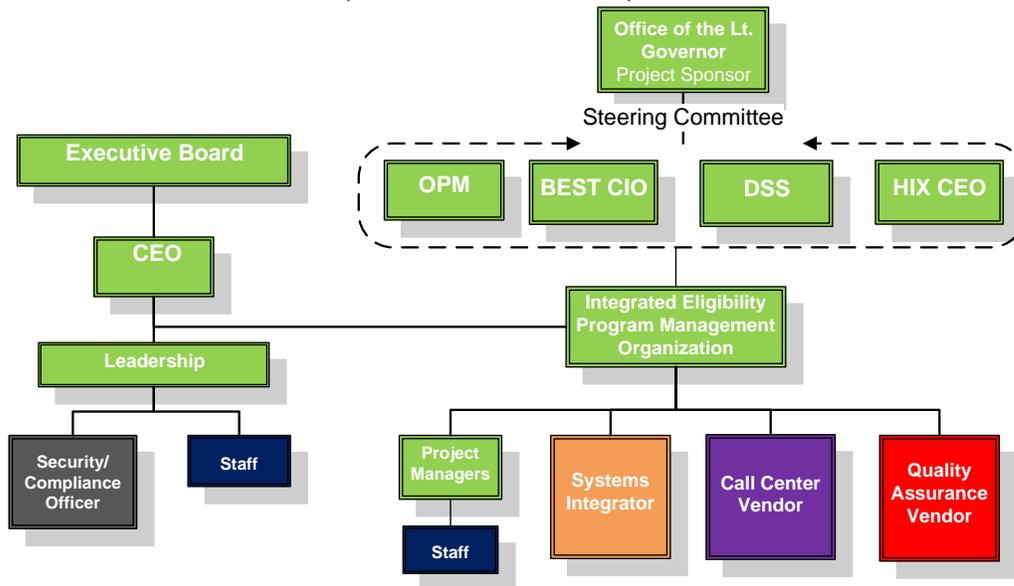


Figure 5: Project Organization

2.6.1. Program Management Organization

The Exchange will leverage an IEPMO to facilitate an overall strategic program integration approach that merges the establishment of the operational side of the Exchange Call Center with the related IT-systems build, staffing, and support requirements. The IEPMO will specifically oversee the development, testing, and implementation of the Exchange Call Center. The IEPMO will assist in standing up the ongoing operations and the implementation of the selected solutions to be within the milestones and deadlines of the Integrated Eligibility and Exchange as prescribed in the ACA. The Exchange will establish the appropriate level of resources to manage and monitor project progress.

The Call Center Vendor is responsible for reporting to the IEPMO on a weekly and monthly basis to detail project progress to date, project risks and issues, and once the Exchange Call Center is operational, report on Service Level Agreement (SLA) metrics.

2.6.2. Quality Assurance (QA)

A QA Vendor will be working with the IEPMO to assist with the quality assurance reviews of Exchange Call Center deliverables on behalf of the Exchange. The Call Center Vendor must fully cooperate with the QA Vendor as it executes its responsibilities. The QA Vendor will review all aspects of the Call Center Vendor activities and report Call Center Vendor status, progress, risks, and remediation approaches to the IEPMO on a routine basis. The QA Vendor will also review Call Center Vendor quality control procedures and processes to develop, track and report on SLA metrics.

2.6.3. Security/Compliance Officer

The Security/Compliance Officer will be responsible for establishing and maintaining the Exchange's vision to ensure information assets are adequately protected. The Security/Compliance Officer will direct the IEPMO in identifying, developing, implementing, and maintaining processes across the

IEPMO to reduce information and IT risks. In addition, the Security/Compliance Officer will respond to incidents, establish appropriate information assets protection standards and controls, and direct the establishment and implementation of information assets protection policies and procedures. The Call Center Vendor is expected to collaborate with the Security/Compliance Officer on compliance with established information assets protection policies and procedures.

2.6.4. Exchange Team

The Exchange will make resources available to the extent possible as requested by the Call Center Vendor. The Responder should include in its response any expectations and needs for the Exchange staff participation in the effort, including key participants, deliverable review assumptions, and meeting attendance requirements. Specific expectations of Exchange team participation should be clearly outlined in the Responder's Exchange Call Center proposal and those activities should be included in the work plan (in Microsoft (MS) Project format) to be included with the Exchange Call Center Proposal.

3. SCOPE OF WORK

3.1. Project Timeline

3.1.1. Target Completion/Critical Due Dates

The following are the anticipated target dates for key milestones:

Activity	Date
RFP Issued	October 5, 2012
Responder Submission of Intention to Propose	October 10, 2012
Questions Regarding Proposal	October 22, 2012
Proposal Due Date	November 5, 2012
Oral Presentations for Selected Finalists	November 6-16, 2012
Vendor Award	November 30, 2012
Exchange Certification by the Center for Consumer Information and Insurance Oversight (CCIIO)	January 1, 2013
Anticipated Contract State Date	April 1, 2013
Final Roll out of Exchange Call Center	September 1, 2013
Accept pre-enrollment applications for the MAGI population	October 1, 2013
Process applications and run eligibility for MAGI benefits	January 1, 2014

3.1.2. Contract Term

The initial term of the contract shall be from the date specified in the executed contract up until three (3) years of services have been performed (by August 31, 2016). The Exchange shall possess the option to extend the contract for additional periods of time, up to an additional 24 months, at the sole discretion of the Exchange. Extensions will be accomplished as stated in the executed contract. In the event that the contract, if any, resulting from the award of this RFP shall terminate or likely to be terminated prior to the making of an award for a new contract for the identified products and/or services, the State may, with the written consent of the Call Center Vendor, extend the contract for such period of time as may be necessary to permit an uninterrupted transition of services. The contract may also be amended in writing from time to time by mutual consent of the parties. The Exchange reserves the right to adjust the initial contract term prior to contract execution based on availability of funds and other factors relevant to the Exchange.

3.2. High Level Requirements

Connecticut's Exchange Call Center will support the core operations requirements for eligibility determination for the Exchange (e.g., APTCs, CSRs), Medicaid, and CHIP. The IE platform (e.g., shared eligibility service), once designed, developed and implemented, will provide a seamless eligibility and enrollment process with Medicaid/CHIP, and ultimately with other State social services programs (e.g., SNAP, TANF). The State will then implement a rules engine that will determine eligibility for QHPs, APTC, CSR, and MAGI Medicaid and CHIP which the Exchange Call Center will rely on. The Exchange Call Center will refer the MAGI Medicaid and CHIP eligible applicants to DSS for enrollment and ongoing case management. Enrollment for non-Exchange applicants (e.g., Medicaid/CHIP) will be completed by DSS Benefits Center.

The State encourages the Responder to propose a way in which the Exchange Call Center will most effectively coordinate with the DSS Benefits Center and other referral agencies in ensuring the quality of the customer service and best coordination with the Exchange overall requirements.

A detailed Requirements Traceability Matrix is included in Appendix B. Each Responder will complete the Requirements Traceability Matrix as described in Section 4.5: Level of Fit of the Proposed Solution.

3.3. Business Process Models

The Exchange has developed a number of High Level Business Process Models included in Appendix A. The Business Process Models provide the Responder with an understanding of the planned Exchange transaction and process flows. The following table is an inventory of the business process models, including a high-level description of the processes that are applicable to the Exchange Call Center.

Table 4 – Future State Consumer Assistance Business Process Models

Process Model	Description
BP-CA-FS-01: Initiate/Resolve Inquiry	This process flow depicts the course of a consumer reporting and resolution of an inquiry to the Exchange.
BP-CA-FS-02: Initiate/Resolve Complaint	This process flow depicts the course of a consumer reporting and resolution of a complaint filed to the Exchange.
BP-CA-FS-03: Provide Eligibility Assistance	This process flow depicts the course of a consumer seeking information on eligibility and enrollment and handling of such processes by Consumer Support for the Exchange.
BP-CA-FS-04: Consumer Satisfaction Survey	This process flow depicts the consumer satisfaction review conducted by the Exchange. This process measures a consumer’s satisfaction with the outcome of the inquiry or complaint resolution and validates that there are no more steps to be taken.
BP-CA-FS-05: Plan Comparison	This process flow depicts the course of a consumer reporting and resolution of an inquiry related to plan comparison/enrollment to the Exchange.
BP-CA-FS-06: Process Re-enrollment	This flow depicts the annual re-enrollment process used by the Exchange.
BP-CA-FS-07: Change of Status	This process flow depicts the process taken for changing the status of a consumer’s benefits. Change of status can be triggered by Eligibility Management System (EMS), DSS, the Carrier, or requested by the consumer.
BP-CA-FS-08: Broker/Navigator Acct. Mgmt.	This process flow depicts the course of a broker/navigator reporting and resolution of an inquiry related to their account management to the Exchange.
BP-CA-FS-09: Broker/Navigator Client Mgmt.	This process flow depicts the course of a broker/navigator reporting and resolution of an inquiry related to their client management to the Exchange.

4. PROPOSAL INSTRUCTIONS

The following is a list of requirements and guidelines regarding the Responder's Exchange Call Center proposal.

4.1. Proposal Outline

The Responder's Exchange Call Center proposal should consist of the following sections, in the order listed below:

- Cover Letter
- Table of Contents
- Executive Summary
- Organizational Capability
- Approach and Methodology
- Level of Fit of the Proposed Solution
- Project Timeline
- Scope Exclusions
- Cost/Pricing Proposal

4.1.1. Document Formatting

The proposal created by the Responder should be formatted as follows:

- Paper size: 8.5 x 11 inches, double sided
- Minimum font size: 11 point (except for footnotes, headers, or footers)
- Ready for printing: All electronic files submitted will be pre-formatted for printing
- Requirements Traceability Matrix should be submitted in MS Word format.
- Proposal should be submitted in either PDF or MS Word format.

4.1.2. Organization of Response

The Responder is required to submit:

- Ten (10) soft copies on CD-ROMs which will contain all documents (this is in addition to a submission of a hard copy of the proposal).
- Six (6) hard copies in binders organized in the order as specified above. Documents should be separated by tabbed dividers within the binder.

4.2. Executive Summary

The Responder shall provide, as a separate section, an Executive Summary of their proposal. The Executive Summary should communicate the Responder's commitment to serving the interests of the Exchange, its approach, and the value-added capabilities to an Exchange executive-level audience.

4.3. Organizational Capability

Describe the Responder's organizational capability to provide the scope of services described in this RFP. To demonstrate organizational capability, provide the following:

- A description of the company, including when it was established, number of employees, locations of corporate offices, and which offices the staff that will be assigned to the project are affiliated.
- State the number of Call Centers the Responder has implemented and operated and the number of employees with relevant training and experience in operating Call Centers for health and human services and health insurance programs.
- State whether parts of the services proposed are to be provided by a subcontractor and, if so, describe the relationship with the proposed subcontractor and the proposed subcontractor's role during this engagement.

4.3.1. Responder Qualifications

The Responder should describe their experience in operating similar Call Centers for three (3) or more environments of comparable size and complexity over the past five (5) years. While the Responder should demonstrate the breadth and depth of their experience, they should also highlight experience in delivering these solutions to State and/or Federal government clients.

Responders should document their experience using the structure below. Experience descriptions should include:

- Summary descriptions of the client organization (size, geographic location, scope, industry, etc.).
- Brief descriptions of consumer assistance services provided
- Scope of the effort in terms of total project cost (to the client), duration of the project, and team size (Responder resources).

Client Name/Organization	
Client Size, Geographic Location, Industry	
Consumer Assistance Services Provided	
Solution Technical Description	
Consumer Population Served (Number of Consumers)	
Project Cost	
Project Start and End Dates	
Project Team Size	

4.3.2. Responder References

A key differentiator will be the length, service levels, references, and quality of comparable Call Center services provided to other clients. The Responder must provide contact information for a minimum of three (3) client references that the Exchange can contact. These references should be drawn from the projects summarized in Section 4.3.1: Responder Qualifications. The Responder will also ensure that the Exchange is able to have appropriate access to the reference contacts listed, and should expect that such reference contacts will be contacted by the Exchange.

The three (3) references should be documented using the structure below:

Client Name/Organization	
Contact Name	
Contact Title and Project Role	
Phone Number	
E-Mail	

4.3.3. Assumptions

In addition to Scoping and Administrative assumptions, the Responder should identify any assumptions being made with respect to this service request as discussed in Section 2.5: Assumptions.

4.3.4. Staffing Plan

- Provide a brief narrative summarizing the Responder's staffing plan, which identifies the number of staff required to support this project.

- For each proposed resource, clearly indicate which will be dedicated to this project on a full-time equivalency basis. Please note that the Exchange is expecting a dedicated set of resources that are committed to this project and its timely success.
- Provide an organizational chart for this project, showing the Responder's team and how it will interact with the Exchange and its supporting entities. Also, include a narrative describing the organization and interactions.
- List all roles and key resources proposed for the project. The Responder must list the key staff as well as additional staff needed to complete the project.
- At a minimum, key staff should include the Exchange Call Center Manager. The Exchange Call Center Manager must have:
 - A minimum of five (5) years of experience in managing call centers, including performing and maintaining appropriate service levels and quality to all users, customers and stakeholders.
 - A minimum of seven (7) years of experience in call center operations.
 - Demonstrated knowledge of the business architecture, information architecture, and technical architecture standards and guidance from the ACA, the federal government's guidance for Exchanges, and key components of NIEM.
 - Experience in an MMIS, CHIP, health insurance or other government health service call center.
- The Exchange reserves the right to interview, screen, and approve or deny all resources proposed for the assignment and request references as needed.
- The Exchange also reserves the right to request reasonable changes to specific team resources because of their availability, qualification, skill-sets, and quality of work products and deliverables.
- Please include resumes as an appendix that highlights relevant skills and qualifications of all key staff proposed. The Responder must demonstrate the project team's ability to deliver the proposed solution. Also, include three (3) client references for all key staff proposed (Name, title, phone, e-mail, and project).

4.4. Approach and Methodology

The proposed Exchange Call Center development and operations approach should have sufficient detail to ensure that the Exchange can understand and anticipate how the services will be delivered in a standard approach based on the Responder's best practices and experiences with similar clients. This section while addressing the entire scope of the Responder's solution should specifically articulate within it:

4.4.1. Achievement of the Exchange/IE Objectives

The Responder will describe how their solution fulfils the Exchange/IE objectives as described earlier in Section 2.2.2: Future State.

4.4.2. Integration with Connecticut Call Centers

The Responder should describe how their Exchange Call Center services will integrate with the State's Call Centers as described throughout this document.

4.4.3. Off-site Services

The Responder shall describe the proposed services that may be delivered from non-CT locations but within the United States. While Federal guidelines require the Call Center to be located in the US, Call Center personnel do not need to be US citizens. However, Exchange Call center personnel are required to be authorized to work in the United States. The description should include a detailed

explanation of the delivery model, touch points, resource pyramid (i.e., mix of senior, mid, and junior level resources), communication protocols, team experience levels, travel requirements, data security and other integration considerations as deemed relevant. Additionally, please describe the method by which user experience is measured and how performance is improved.

4.4.4. Processes and Methodologies

The Responder shall describe the major processes and methodologies that it will be employed in delivering the Services. The Responder should address how they will integrate their processes and tools with the various State benefit program call centers as described throughout this document.

4.4.5. Dedication to Quality

The Responder shall supply the Exchange with a Quality Assurance Plan associated with performance tools, processes and knowledge. The Responder should provide details of its approach to measuring and maintaining high quality services. The Responder should supply details of any industry-recognized quality standard to which it is, or will become, compliant (including a timeframe for compliance, if not already achieved), as well as any awards received over the last 18 months. Please indicate all quality programs that are externally measured (e.g., Six Sigma, ISO 2000, ITIL, etc.) and how such certifications would directly benefit the Exchange Call Center.

4.4.6. Information Security, Data Privacy, and Sarbanes-Oxley (SOX) Compliance

The Responder must describe its approach to managing information security, data privacy, and SOX compliance as part of its solution.

4.4.7. Transition and Knowledge Transfer Plan

The Responder should further describe how it will transition services from the Exchange's current environment to the Responder's proposed solution. The Responder should also describe its expectations of the State in support of the transition. The Transition Plan should include a high-level discussion of the following elements:

1. Description of Responder transition methodology and philosophy, including knowledge transfer and aspects of risk-mitigation.
2. Transition roles and responsibilities (including expectations of involvement and commitment of the Exchange).
3. Expected Transition Plan deliverables (including responsibility and acceptance criteria).
4. Description of transition approach for the Exchange, including elements such as:
 - a. Phases
 - b. Timeline (high-level)
 - c. Service changes required to move to outsourced model
 - d. Process specific transition approach
 - e. Any off-site location requirements/impacts
 - f. Communication approach and responsibilities
 - g. Knowledge transfer approach and responsibilities
 - h. Readiness testing/assessment approach and responsibilities
 - i. Acceptance procedures
5. The Responder's suggested approach for Transition governance
6. Description of metrics that will be used to identify the establishment of a post-transition "steady state".

4.4.8. Training Plan

The Call Center Vendor shall partner with the Exchange to develop the appropriate method of delivering the training (i.e., classroom, Web-based, etc.) and associated training materials for Tier 1 and Tier 2 Exchange Consumer Support. Once the method and materials have been determined, the

Call Center Vendor shall provide a formal training plan to the Exchange. Included within this plan, the Call Center Vendor should provide action plans for Exchange Call Center personnel that fail to demonstrate the required skills and knowledge. These action plans will serve as an aid to verify that the Exchange Call Center personnel skill sets are up-to-date to fulfill the required responsibilities. The Call Center Vendor should not overlook any training that is required for the call center representatives to need. Please refer to Appendix B: Requirements Traceability Matrix for more details about the training requirements.

4.4.9. Disaster Recovery / Business Continuity Capabilities

This section is intended to provide sufficient detail to understand each Responder's capabilities with regard to an event which impacts the Responder's ability to deliver the Services.

The Proposal should address the following topics:

- Provision of continuous operations of the services (including the underlying systems for which the Responder is responsible)
- The Exchange's involvement in developing a Future State disaster recovery plan
- The Exchange's involvement in any actual recovery processes
- Incorporation of the Exchange's corporate standards/expectations for disaster recovery into the initial and on-going disaster recovery plans
- The scope of disaster recovery testing and requirements for the Exchange's participation in such testing
- Risks and liabilities to be assumed by the Responder
- The impact on pricing of different scenarios or recovery levels

4.4.10. Governance Approach

The Exchange believes that the governance operating model is critical to the success of this outsourcing initiative. The Responder should describe its governance operating model including governance hierarchy, contract administration, performance monitoring and reporting, project management, financial management, decision rights between the parties, interfacing with the functions, and other enterprise stakeholders. Specifically, the Responder should include enough detail to differentiate its best practices and operating models on governance structure and protocols (steering committees, meeting type and frequency, etc.), relationship touch-points and checkpoints, service delivery policy/procedures/process descriptions and tools. Be specific about any ready-to-deploy web-based tools, or third party tool provider arrangements and/or alliances that will provide additional value to the management and alignment of the relationship.

4.4.11. Exchange Call Center Responder's Value Add Capabilities

As a separate document, the proposal should describe how the Responder would add value to the described areas. The Responder should describe any unique capabilities it possesses for assisting the State in achieving additional improvements and describe how it will make such capabilities available to the Exchange. Examples would include Responder's capabilities related to Call Center tools, knowledge, self service capabilities, telephony options, support of rationalization and transformation activities, and innovation. If the Responder has notable capabilities that fall outside the scope of this RFP, but may have considerable value to the Exchange, they are encouraged to describe those capabilities in their proposals. Describe how the value-add capabilities could be applied to the Exchange environment.

4.5. Level of Fit of the Proposed Solution

Based on the proposed solution, the Responder should complete the attached Requirements Traceability Matrix (Appendix B) to indicate the proposed solution's level of fit with the State requirements included in Section 3.2: High Level Requirements.

The Responder must respond as either yes ("Y") or no ("N") in the "Responder Comply (Y/N)" column of the attached Requirements Traceability Matrix. The purpose of the Responder's response is to indicate whether the Responder is compliant with the detailed requirements. If "N" is selected as the response to any of these requirements, the Responder is required to submit a justification and reasoning as to why the requirement is not met under the "Responder Response" column. Additional details can be found in Appendix B.

4.6. Project Timeline

Provide a high-level description of the Responder's envisioned timeline for this project. The timeline should be based on a full project plan and include all of the milestones and deliverables in Section 3.1 Project Timeline.

The Responder should provide a description of the major tasks to be performed, by phase and with associated deliverables, and must utilize the milestones and associated deliverables outlined in this RFP.

The Responder should provide a work plan in MS Project format that details the tasks and activities, durations, dependencies, and resources based on the proposed approach and methodology, which will be executed to create the noted deliverables, complete the call center roll-out, and manage call center operations.

Please note that the Exchange's expectations around the project duration are outlined in Section 2.1: Scope of Solicitation.

4.7. Scope Exclusions

Explicitly list what the Responder considers to be outside of the scope of the project.

4.8. Cost/Pricing Proposal

This section describes the Cost Proposal RFP submission requirements for consideration and evaluation. Cost data will not be examined until after the evaluation team has determined that the Responder's proposal is fully compliant with the format and mandatory requirements of this RFP.

The Responder will provide in the cost proposal a firm fixed price for the development, certification, and deployment of all Exchange Call Center components, including IVR system. The fixed price should be representative of the "stand up" cost of the proposed Exchange Call Center solution.

For Exchange Call Center operations costs starting September 1, 2013, the Responder will include a cost proposal at a capitated Per Member Per Month (PMPM) fee for all services, hosting, licensing, operations, maintenance and enhancements of the solution. Note that the PMPM fee should be derived from estimates using utilization for a target population described in Section 2.2.3: Volumetrics and should account for the two interaction scenarios. The State expects however that the Responder has the necessary expertise to properly anticipate load and staffing requirements for the Exchange Call Center. Responder services and responsibilities included in the PMPM fee are listed in Appendix B: Requirements Traceability Matrix.

Moreover, licensed Brokers will be utilized in the event that consumers will require support with selecting a QHP plan, as described in Section 2.2.2: Future State. Note that these Brokers must be licensed for at least 18 months in order to comply with the federal regulations. The Responder is required to submit two pricing structures for Exchange Call Center operations that are reflective of both opportunities to leverage licensed Brokers, including:

- Pricing Structure 1 – The Exchange Call Center is staffed with an adequate number of in-house licensed Brokers to provide consultative insurance selection advice. Note, that the Call Center Vendor will be responsible to ensure that the Brokers on staff are certified in Connecticut and that an adequate number of brokers is available to answer consumer inquiries related to selection of insurance products;
- Pricing Structure 2 – The Exchange Call Center is NOT staffed with in-house Brokers, however consumers are transferred to outside Brokers licensed in a particular consumer area to answer any inquiries related to selection of insurance products.

Cost Proposal Template

Fixed Price to Stand Up Proposed Exchange Call Center Solution		+	PMPM Cost for Exchange Call Center Operations		
Development, certification, and deployment of all Exchange Call Center components	\$ (fixed price)		Section 2.2.3: Volumetrics	Licensed Brokers on staff (Pricing Structure 1)	Transfer to Outside Brokers (Pricing Structure 2)
			Scenario 1 (Moderate Automated Interaction)	\$ / PMPM	\$ / PMPM
			Scenario 2 (Highly Automated Interaction)	\$ / PMPM	\$ / PMPM

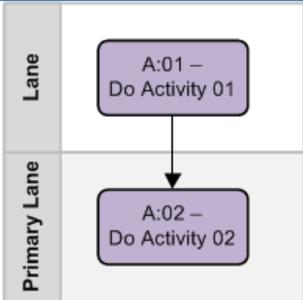
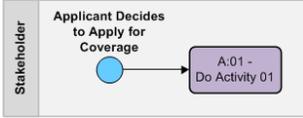
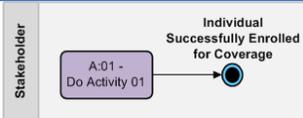
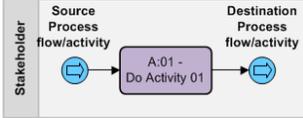
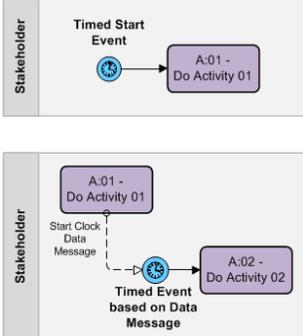
In addition to the pricing methodology requested by the Exchange in this RFP, Responders may submit alternative pricing proposals for consideration. The Exchange reserves the right to select the compensation approach that it believes is in the best interest of the Exchange.

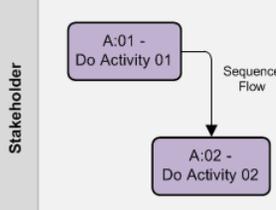
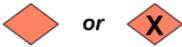
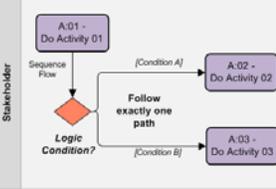
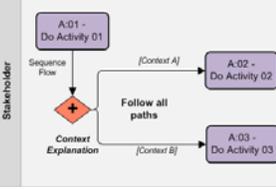
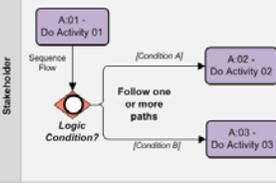
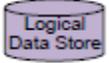
The Responder should also include a time and materials hourly rate card for additional services.

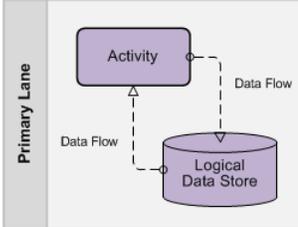
THE EXCHANGE RESERVES THE RIGHT TO REJECT ANY AND ALL BIDS OR ANY PART THEREOF.

Appendices

Appendix A – Business Process Modeling Guidance and Business Process Models

Element	Definition	Blueprinting Practices	Example
Swimlane 	<ul style="list-style-type: none"> Swimlanes assign responsibility to the activities in the process Swimlanes can be an organization, a role, or a system 	<ul style="list-style-type: none"> Swimlanes represent stakeholder organizations The primary swimlane of focus (e.g., the Exchange) is shaded to assist in identification of activities associated with the primary stakeholder in the flow Swimlanes are ordered to improve readability across process flows 	
Activity (or task) 	<ul style="list-style-type: none"> Represents the work to be performed 	<ul style="list-style-type: none"> Activity names follow a standardized naming convention consisting of a unique ID and descriptive name Adhere to Verb-Noun pattern for activity names Activities have only one outgoing flow Activities may have multiple incoming flows 	
Start Event Start Event 	<ul style="list-style-type: none"> Indicates start point for a process 	<ul style="list-style-type: none"> Label the event that starts the process E.g., Applicant Decides to Apply for Coverage 	
Termination Event Termination Event 	<ul style="list-style-type: none"> Triggers the immediate termination of a process 	<ul style="list-style-type: none"> Label the event (or state) that terminates the process E.g., Individual Successfully Enrolled for Coverage 	
Linked Event Link Event 	<ul style="list-style-type: none"> Off page connectors to other process flows 	<ul style="list-style-type: none"> Embed the source (or destination) process flow name and associated activity ID in the event name 	
Timed Event Timed Event 	<ul style="list-style-type: none"> Cyclic timer events, points in time, or timeouts 	<ul style="list-style-type: none"> Label the timed event that starts the process Used in conjunction with data messages to start a timed event based on a pre-condition set in another activity 	

<p>Sequence flow Sequence Flow →</p>	<ul style="list-style-type: none"> Defines the execution order of activities 	<ul style="list-style-type: none"> List information items on sequence flows, where appropriate (note that this is a short hand representation for data flows) 	
<p>Exclusive Gateway <i>Exclusive Gateway</i></p> 	<ul style="list-style-type: none"> When splitting, exactly (only) one outgoing branch is triggered When merging, one incoming branch must complete before triggering the outgoing flow 	<ul style="list-style-type: none"> Splitting is frequently used Label the logic statement and the condition <i>Italicize</i> and bold logic statement on the gateway <i>[Italicize]</i> condition on the flow and embed in brackets 	
<p>Parallel Gateway <i>Parallel Gateway</i></p> 	<ul style="list-style-type: none"> When splitting, all outgoing branches are activated simultaneously When merging, all incoming branches must complete before triggering the outgoing flow 	<ul style="list-style-type: none"> Clearly label the gateway and flows with the context <i>Italicize</i> and bold context on the gateway <i>[Italicize]</i> context on the flow and embed in brackets 	
<p>Inclusive Gateway <i>Inclusive Gateway</i></p> 	<ul style="list-style-type: none"> When splitting, one or more branches are activated When merging, all active incoming branches must complete before merging 	<ul style="list-style-type: none"> Clearly label the logic statement and the condition <i>Italicize</i> and bold context on the gateway <i>[Italicize]</i> context on the flow and embed in brackets 	
<p>Logical data store</p> 	<ul style="list-style-type: none"> Place where the process can retrieve or store data beyond the lifetime of the process instance 	<ul style="list-style-type: none"> Logical data stores should be coarse grained and contain only related conceptual data entity types Append the suffix "DS" (Data Store) to the data store name to distinguish it from data flows that may have similar or identical names Include the ID for the activity that created information when labeling the information on a Retrieve flow line from a data store For readability, show data store connections where it makes the most sense in the process (not 	

<p>Data (or message) flow Data Flow</p> <p>●-----></p>	<ul style="list-style-type: none"> • Defines the information flow 	<p>necessarily all activities)</p> <ul style="list-style-type: none"> • Show data flow between activities and logical data stores • Show data flow between two activities to improve readability within a flow • Alternatively, data items may be represented on sequence flows (short hand notation) 	 <p>The diagram illustrates the relationship between an Activity and a Logical Data Store. An Activity (represented by a rounded rectangle) is connected to a Logical Data Store (represented by a cylinder) via two dashed arrows labeled 'Data Flow'. One arrow points from the Activity to the Logical Data Store, and the other points from the Logical Data Store to the Activity. The diagram is enclosed in a box labeled 'Primary Lane' on the left side.</p>
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BP-CA-FS-01: Initiate/Resolve Inquiry

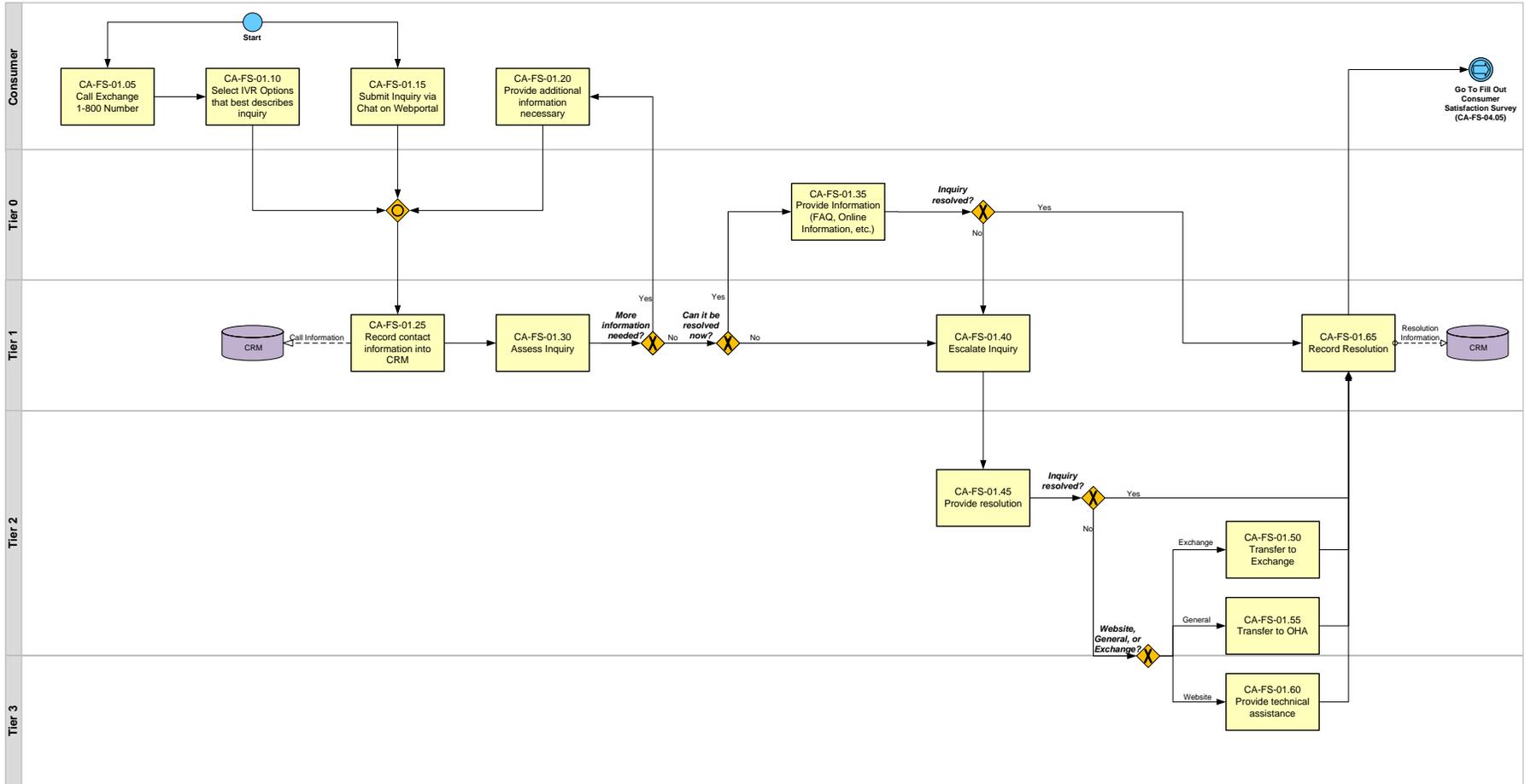
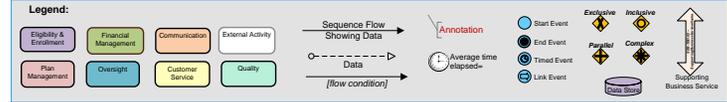
**Generic Exchange Blueprint Process Model
Consumer Assistance Future State**

**BP-CA-FS-01: Initiate / Resolve
Inquiry**

Connecticut Health Insurance Exchange

Synopsis
This process flow depicts the course of a consumer reporting and resolution of an inquiry to the Connecticut Health Insurance Exchange.

Notes
If the current queue exceeds CSR capacity, the CSR will refer to the collected contact information and contact the consumer for proper resolution.



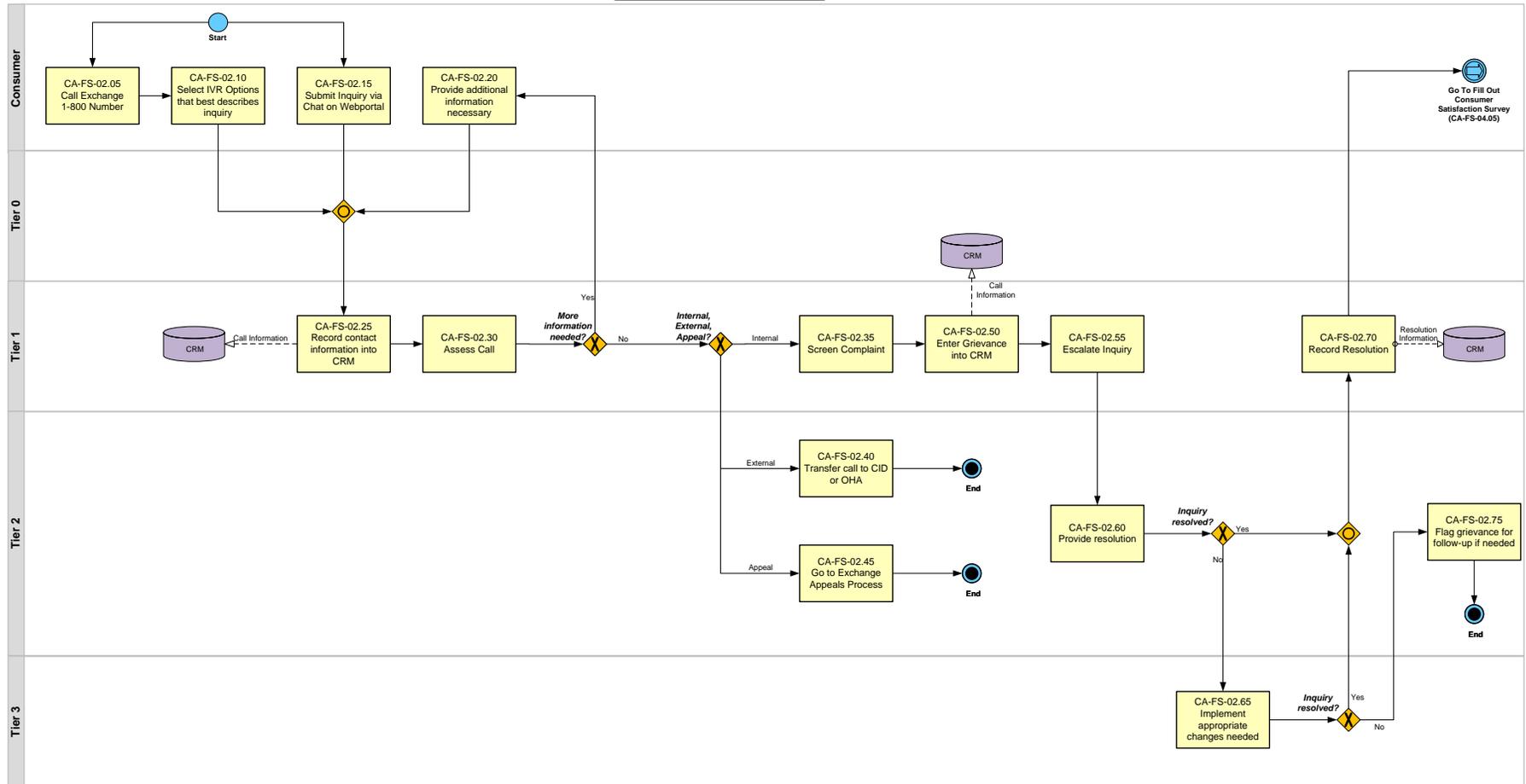
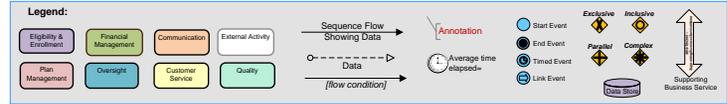
BP-CA-FS-02: Initiate/Resolve Complaint

Generic Exchange Blueprint Process Model
Consumer Assistance Future State

BP-CA-FS-02: Initiate / Resolve Complaint
Connecticut Health Insurance Exchange

Synopsis
This process flow depicts the course of a consumer reporting and resolution of a complaint filed to the Connecticut Health Insurance Exchange.

Notes
If the current queue exceeds CSR capacity, the CSR will refer to the collected contact information and contact the consumer for proper resolution.
Calls transferred to OHA/CID, etc. should utilize a MCI; resolution of transferred calls should be reported to Exchange to allow for tracking of all contacts through resolution.



BP-CA-FS-03: Provide Eligibility Assistance

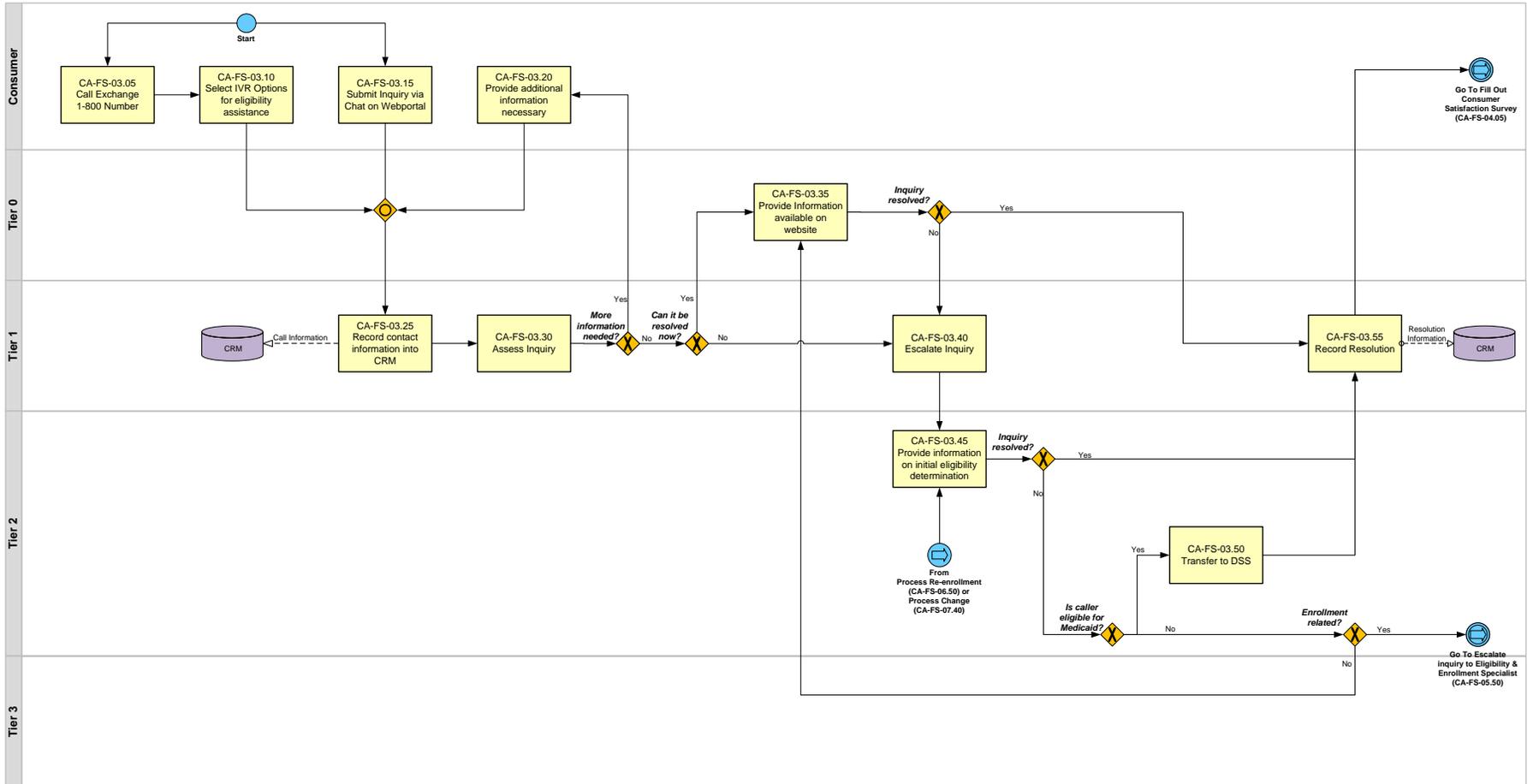
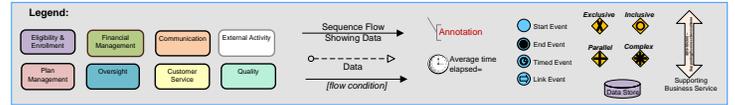
**Generic Exchange Blueprint Process Model
Consumer Assistance Future State**

BP-CA-FS-03: Provide Eligibility Assistance

Connecticut Health Insurance Exchange

Synopsis
This process flow depicts the course of a consumer seeking information on eligibility and enrollment and handling of such processes by Consumer Support for the Connecticut Health Insurance Exchange.

Notes



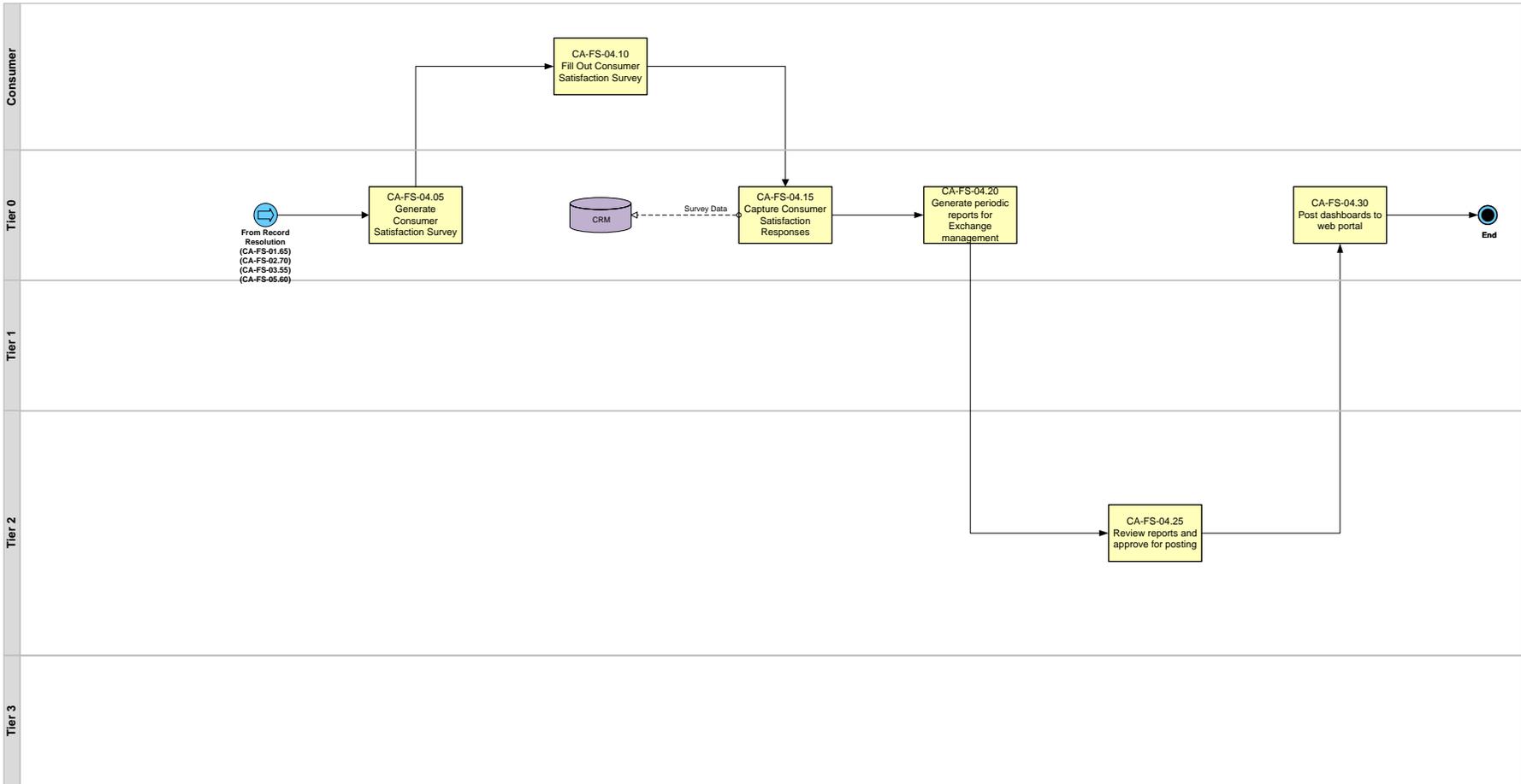
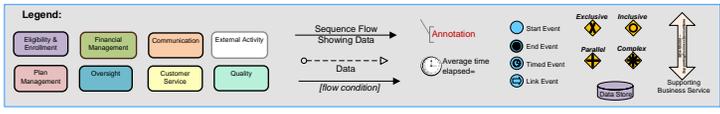
BP-CA-FS-04: Consumer Satisfaction Survey

**Generic Exchange Blueprint Process Model
Consumer Assistance Future State**

BP-CA-FS-04: Consumer Satisfaction Survey
Connecticut Health Insurance Exchange

Synopsis
This process flow depicts the consumer satisfaction review conducted by the Connecticut Health Insurance Exchange. This process measures a consumer's satisfaction with the outcome of the inquiry or complaint resolution and validates that there are no more steps to be taken.

Notes



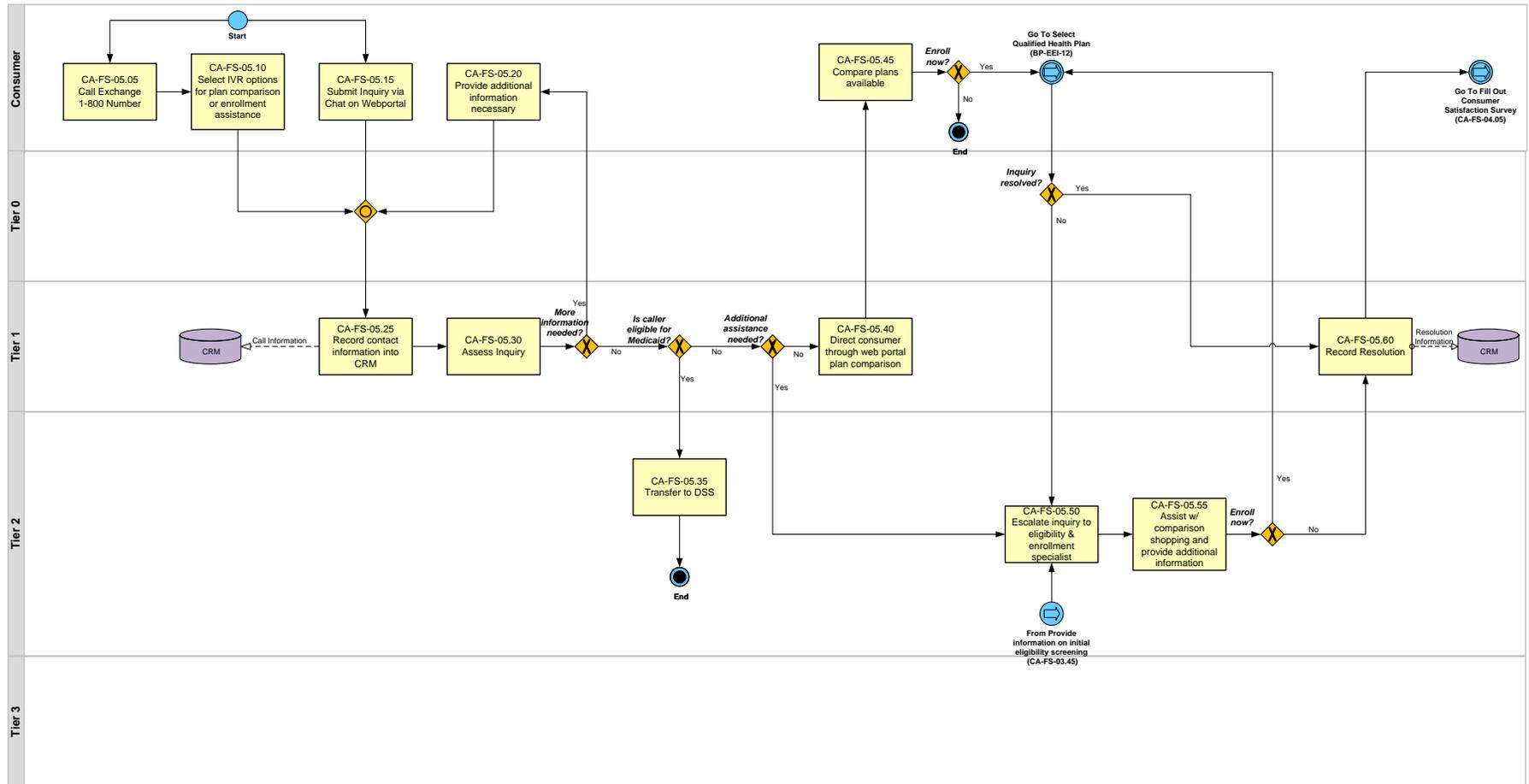
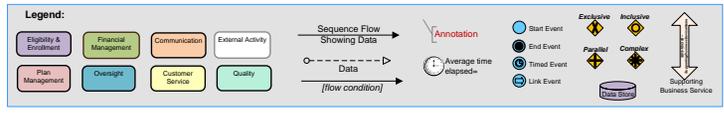
BP-CA-FS-05: Plan Comparison

Generic Exchange Blueprint Process Model
Consumer Assistance Future State

BP-CA-FS-05: Plan Comparison
Connecticut Health Insurance Exchange

Synopsis
This process flow depicts the course of a consumer reporting and resolution of an inquiry related to plan comparison / enrollment to the Connecticut Health Insurance Exchange.

Notes



BP-CA-FS-06: Process Re-Enrollment

**Generic Exchange Blueprint Process Model
Consumer Assistance Future State**

**BP-CA-FS-06: Process Re-enrollment
Connecticut Health Insurance Exchange**

Synopsis
This flow depicts the annual re-enrollment process used by the Connecticut Health Insurance Exchange.

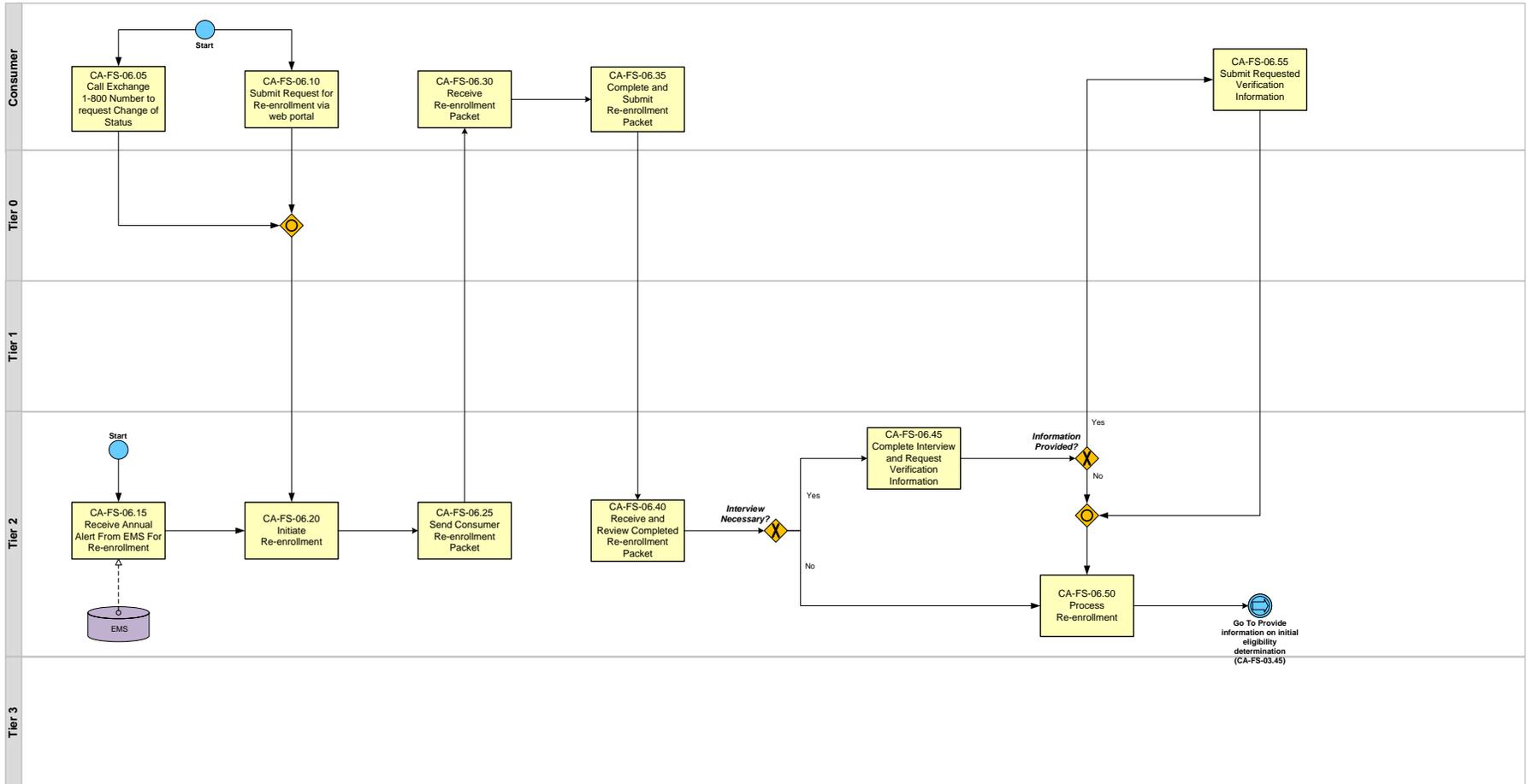
Notes
If the requested verification information is not provided by the consumer, their application is still processed but denied eligibility.

Legend:

- Eligibility & Enrollment
- Financial Management
- Communication
- External Activity
- Plan Management
- Oversight
- Customer Service
- Quality

Sequence Flow: Solid arrow
Showing Data: Arrow with data icon
Data: Dashed arrow
Flow Condition: Arrow with bracket and text

Annotation: Red squiggle
Average time elapsed: Clock icon
Start Event: Blue circle
End Event: Blue circle with slash
Final Event: Blue circle with checkmark
Link Event: Blue circle with double arrow
Exclusive: Diamond with 'X'
Inclusive: Diamond with '+'
Parallel: Diamond with '||'
Complex: Diamond with 'C'
Supporting Business Service: Double-headed vertical arrow



BP-CA-FS-07: Change of Status

**Generic Exchange Blueprint Process Model
Consumer Assistance Future State**

**BP-CA-FS-07: Change of Status
Connecticut Health Insurance Exchange**

Synopsis
This process flow depicts the process taken for changing the status of a consumer's benefits. Change of status can be triggered by EMS, DSS, the Carrier, or requested by the consumer.

Notes
If the current queue exceeds CSR capacity, the CSR will refer to the collected contact information and contact the consumer for proper resolution.
If the requested verification information is not provided by the consumer, appropriate changes are still processed.

Legend:

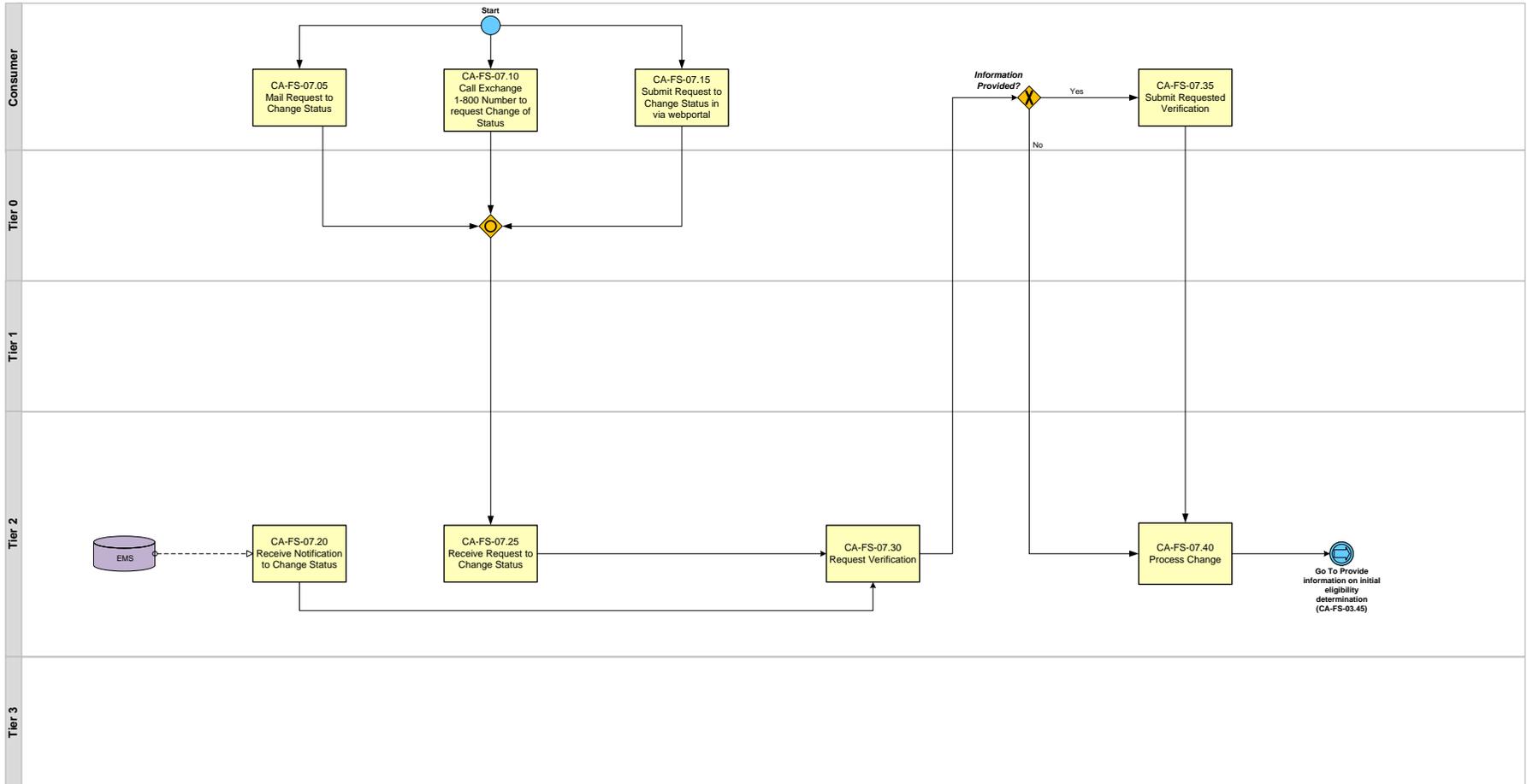
Eligibility & Enrollment	Financial Management	Communication	External Activity
Plan Management	Oversight	Customer Service	Quality

Sequence Flow: Solid arrow
Showing Data: Arrow with open circle
Data: Dashed arrow
[flow condition]: Arrow with bracket

Annotation: Red squiggle
Average time elapsed: Clock icon

Start Event: Blue circle
End Event: Blue circle with slash
Timer Event: Clock icon
Link Event: Blue circle with arrow

Exclusive: Yellow diamond
Inclusive: Yellow diamond with plus
Parallel: Yellow diamond with plus
Complex: Yellow diamond with plus
Supporting Business Service: Double-headed arrow with database icon



BP-CA-FS-08: Broker/Navigator Account Management

Generic Exchange Blueprint Process Model
Consumer Assistance Future State

BP-CA-FS-08: Broker / Navigator
Account Management
 Connecticut Health Insurance Exchange

Synopsis
 This process flow depicts the course of a broker / navigator reporting and resolution of an inquiry related to their account management to the Connecticut Health Insurance Exchange.

Notes
 If the current queue exceeds CSR capacity, the CSR will refer to the collected contact information and contact the consumer for proper resolution.

Legend:

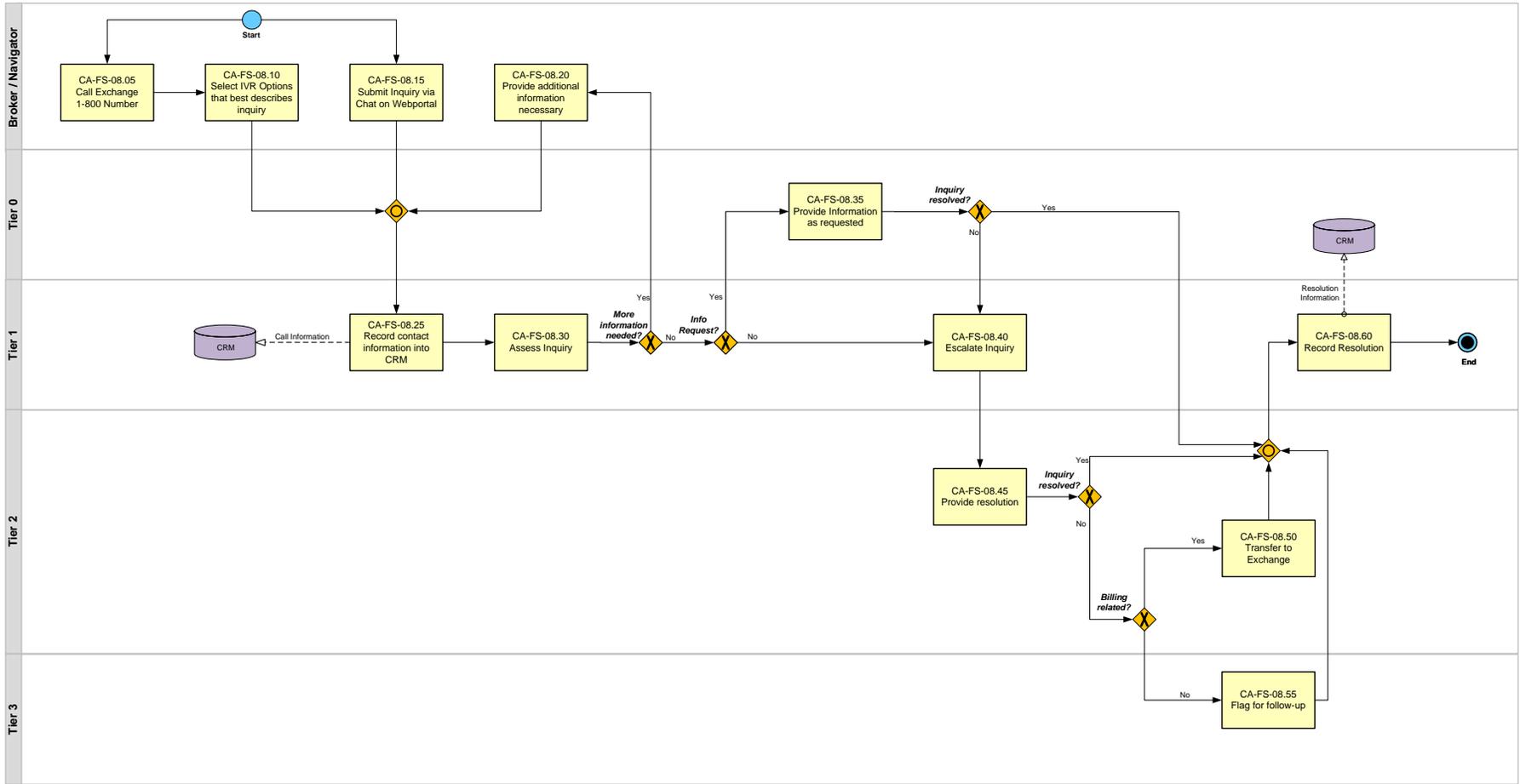
Eligibility & Enrollment	Financial Management	Communication	External Activity
Plan Management	Oversight	Customer Service	Quality

Sequence Flow: Solid arrow
 Showing Data: Arrow with cylinder icon
 Data: Dashed arrow
 (flow condition): Arrow with bracket

Annotation: Red squiggle
 Average time elapsed: Clock icon

Start Event: Blue circle
 End Event: Blue circle with dot
 Trivial Event: Blue circle with horizontal line
 Link Event: Blue circle with vertical line

Exclusive: Yellow diamond
 Inclusive: Yellow diamond with vertical line
 Parallel: Yellow diamond with horizontal line
 Complex: Yellow diamond with diagonal lines
 Supporting Business Service: Double-headed vertical arrow



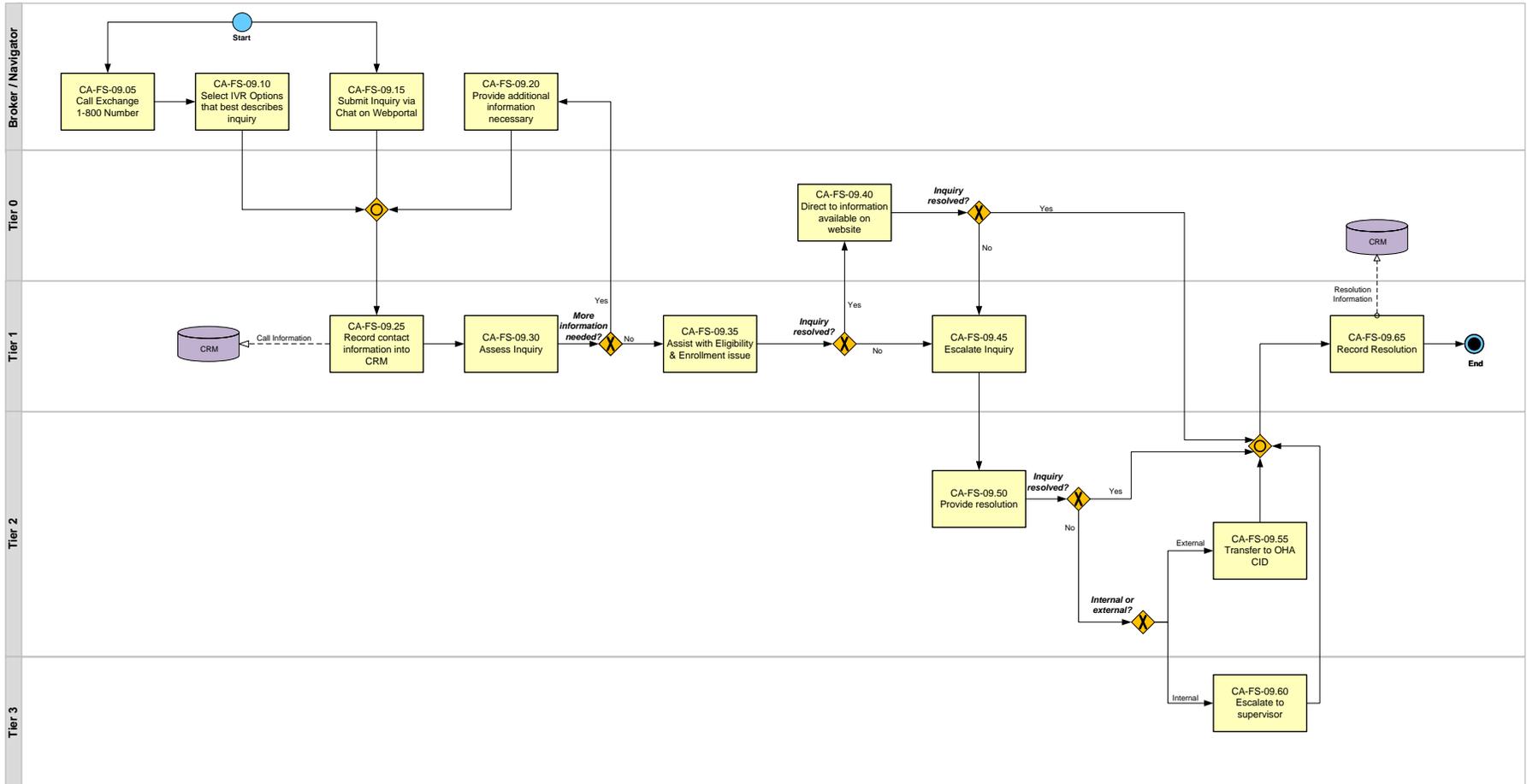
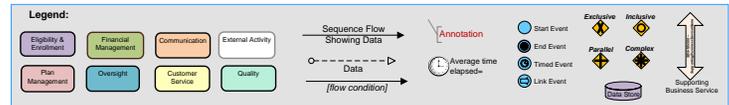
BP-CA-FS-09: Broker/Navigator Client Management

Generic Exchange Blueprint Process Model
Consumer Assistance Future State

BP-CA-FS-09: Broker / Navigator
Client Management
 Connecticut Health Insurance Exchange

Synopsis
 This process flow depicts the course of a broker / navigator reporting and resolution of an inquiry related to their client management to the Connecticut Health Insurance Exchange.

Notes
 If the current queue exceeds CSR capacity, the CSR will refer to the collected contact information and contact the consumer for proper resolution.



Appendix B – Requirements Traceability Matrix

Appendix C – Intention to Propose Form

Intention to Propose

Please return this completed form by email followed by signed copy to the Authorized Contact Person listed in Section 1.1: Authorized Contact Person, by no later than close of business on **October 10, 2012**.

I, _____, an authorized representative of _____, Service Provider, have read the Connecticut Health Insurance Exchange Call Center request for Proposal and has decided to submit its intention to propose for such services on the terms and conditions stated in the RFP and by the due date stated therein.

Service Provider hereby agrees to be bound by and comply with all of the conditions, requirements and protocols set forth in the RFP Instructions.

Agreed and Accepted by:

Name	
Title	
Company	
Telephone	
Date	
Signed	

Appendix D – Notices of Affirmation and Non-Discrimination Representations and Warranties Required of Connecticut Health Insurance Exchange Vendors.

Representations and Warranties:

- 1) The Contractor agrees and warrants that in the performance of any Contract with the Exchange, the Contractor will not discriminate or permit discrimination in any manner prohibited by the laws of the United States or of the State of Connecticut against any person or group of persons on the grounds of race, color, religious creed, age, marital status, national origin, ancestry, sex, sexual orientation, gender identity or expression, genetic information, mental retardation, mental disability or physical disability, including, but not limited to, blindness, unless it is shown by such Contractor that such disability prevents performance of the work involved.
- 2) The Contractor further agrees to take affirmative action to insure that applicants with job-related qualifications are employed and that employees are employed without regard to their race, color, religious creed, age, marital status, national origin, ancestry, sex, sexual orientation, gender identity or expression, genetic information, mental retardation, mental disability or physical disability, including, but not limited to, blindness, unless it is shown by the Contractor that such disability prevents performance of the work involved.
- 3) The Contractor agrees, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, to state that it is an “affirmative action-equal opportunity employer” in accordance with regulations adopted by the Commission on Human Rights and Opportunities (“CHRO”).
- 4) The Contractor agrees to provide each labor union or representative of workers with which the Contractor has a collective bargaining agreement or other contract or understanding and each vendor with which the Contractor has a contract or understanding, a notice to be provided by CHRO, advising the labor union or workers’ representative of the Contractor’s commitments to post copies of the notice in conspicuous places available to employees and applicants for employment.
- 5) The Contractor agrees to comply with Connecticut General Statutes §§ 46a-56, 46a-68e and 46a-68f.
- 6) The Contractor agrees to provide the CHRO with such information requested by the CHRO, and permit access to pertinent books, records and accounts, concerning the employment practices and procedures of the Contractor as relate to the above representations and warranties and Connecticut General Statutes § 46a-56.
- 7) If the contract is a public works contract, the Contractor agrees and warrants that it will make good faith efforts to employ minority business enterprises as subcontractors and suppliers of materials on such public works projects.

Good Faith Efforts

- 1) Determination of the Contractor's good faith efforts shall include, but shall not be limited to, the following factors: The Contractor's employment and subcontracting policies, patterns and practices; affirmative advertising, recruitment and training; technical assistance activities and such other reasonable activities or efforts as the CHRO may prescribe that are designed to ensure the participation of minority business enterprises in public works projects.
- 2) The Contractor shall develop and maintain adequate documentation, in a manner prescribed by the CHRO, of its good faith efforts.
- 3) The Contractor shall include the provisions contained above under Representations and Warranties sections 1 through 7, in every subcontract or purchase order entered into in order to fulfill any obligation of a contract with the Exchange and such provisions shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the CHRO. The Contractor shall take such action with respect to any such subcontract or purchase order the CHRO may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with Connecticut General Statutes § 46a-56; provided if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the CHRO, the Contractor may request the Exchange to enter into any such litigation or negotiation prior thereto to protect the interests of the Exchange and the Exchange may so enter.
- 4) The Contractor agrees to comply with the statutes and regulations cited above as they exist on the date of the Contract and as they may be adopted or amended from time to time during the term of this Contract and any amendments thereto.

Appendix E – Notice of State Ethics Representations and Certifications Required of Connecticut Health Insurance Exchange Vendors

- 1) For all contracts as defined in P.A. 07-01 having a value in a calendar year of \$50,000 or more or a combination or series of such agreements or contracts having a value of \$100,000 or more, the authorized signatory to the contract must expressly acknowledge receipt of the State Elections Enforcement Commission's notice advising state contractors of state campaign contributions and solicitation prohibitions and will inform its principals of the contents of the notice.
- 2) Pursuant to Governor M. Jodi Rell's Executive Order No. 1, paragraph 8, and Governor M. Jodi Rell's Executive Order No. 7C, paragraph 10(a), the Contractor must submit a contract certification annually to update previously-submitted certification forms for state contracts. Contractors must use the Gift and Campaign Contribution Certification (CT HIX Ethics Form 1) for this purpose. The first of these Ethics Form 1 certifications is due on the first annual anniversary date of the execution of the contract and subsequent certifications are due on every succeeding annual anniversary date during the time that the contract is in effect, including the first anniversary date following the termination or expiration of the contract or conclusion of the Services. This provision shall survive the termination or expiration of the contract in order for the Contractor to satisfy its obligation to submit the last certification.
- 3) The Contractor shall comply, to the extent applicable, with the provisions of Executive Order No. Three of Governor Thomas J. Meskill, promulgated June 16, 1971, concerning labor employment practices, Executive Order No. Seventeen of Governor Thomas J. Meskill, promulgated February 15, 1973, concerning the listing of employment openings, Executive Order No. Sixteen of Governor John G. Rowland promulgated August 4, 1999, concerning violence in the workplace and Executive Order No. 7C of Governor M. Jodi Rell, promulgated July 13, 2006, concerning contracting reforms. These Executive Orders will be incorporated into and made a part of all contracts with the Exchange as if they had been fully set forth in the contract. At the Contractor's request, the Exchange shall provide a copy of these orders to the Contractor.