Addendum 1

Medicare Maximization Request for Proposals
State of Connecticut Department of Social Services
MMX_RFP_022912

The State of Connecticut Department of Social Services is issuing **Addendum 1** to the **Medicare Maximization Request for Proposals**.

Addendum 1 contains:

1. An amendment to the original RFP issued on February 29, 2012; and

2. Questions and Responses.

1. The amendment to the original RFP in SECTION III PROPOSAL FORMAT REQUIREMENTS D. PROPOSAL CONSTRUCTION REQUIREMENTS 4. is as follows:

   Cross-referencing RFP and Proposal - Each section of the proposal must cross-reference the appropriate section of the RFP that is being addressed. Proposal responses to specific task requirements must reference the RFP request citation. This will allow the Department to determine uniform compliance with specific RFP requirements.

   Deleted: All responses must correspond to the specific assigned task number in the RFP and shall follow the sequence order found in the RFP.

2. 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**: Are we correct that the original Proposal is to be submitted in two separate loose-leaf notebooks? If not, please clarify these submission requirements.

      Response: Yes, you are correct.

   2. **Question**: Are we correct that each copy of the Proposal is also to be submitted in two separate loose-leaf notebooks? If not, please clarify these submission requirements.

      Response: Yes, you are correct.

   3. **Question**: Are we correct that all the notebooks and CDs or DVDs can be submitted to the Department together in a sealed box? If not, please clarify these submission requirements.

      Response: Yes, you are correct.

4. **Question**: The required Proposal Outline (RFP, p.54) is in a different format and sequence than the RFP itself. (Example: **A. Cover Sheet,** followed by Arabic numbers in the Proposal Outline and **1. Cover Sheet, followed by lower case letters** in the RFP.) Yet Section III. D.4.of the RFP states that "All responses must correspond to the specific task number in the RFP and shall follow in the sequence order found in the RFP." (p.18.) Can you please clarify?

   a. Shall we follow the Proposal Outline format and sequence (p. 54) or the format used in Section IV, Part Five et seq (p.20)? If there is another format required, please explain.

   Response: In Section III. D.4.of the RFP, the statement: "All responses must correspond to the specific task number in the RFP and shall follow in the sequence order found in the RFP" (page 18.) has been eliminated from the RFP, as an amendment in this addendum. Please refer to number 1. of this addendum.

   Please follow the Proposal Outline format and sequence found on page 54.

5. **Question**: On page 30 of the RFP, and throughout, the term "Root Cause Corrective Action Plan" is used. Can you please define this term and its requirements?

   Response: A Root Cause Corrective Action Plan is determining causes that led to a problem and creating corrective action to improve upon the event or prevent a recurrence of the event.

   Please refer to RFP Section B. Scope of Services, B.2. SNF/CDH Specific MMX Respondent and Contractor Requirements, 4. as these are Root Cause Corrective Action Plan requirements.

6. **Question**: How many Medicaid paid claims were there for Chronic Disease Hospital care from January 1, 2011 – December 31, 2011? Please note: In Question # 6, we are looking for information regarding Medicaid paid claims for dually eligible people.

   Response: By date of payment: 1,255; by date of service: 1,122

7. **Question**: What was the dollar value of Medicaid paid claims for dually eligible people for Chronic Disease Hospital care from January 1, 2011 – December 31, 2011?

Response: By date of payment: $35,921,851; by date of service: $32,819,329

8. **Question**: Will Connecticut hire more than one vendor to perform the services?

   Response: Per the RFP: It is the Department's intent to award one contract for services described in the RFP. The Department reserves the right to fund more than one contract if desired.

9. **Question**: Will Connecticut consider payment options, other than a per case cost?

   Response: For purposes of the evaluation process, a **per case cost** is the only cost option requested as a requirement of this RFP. Upon the offer of the right to negotiate a contract to the recommended Respondent, different payment methodologies may be discussed, not to exceed the Respondent's proposed cost included in their proposal.

10. **Question**: Can the vendor propose new/other revenue projects under this procurement to increase cost-savings related to Medicare maximization?

    Response: No, the Request for Proposal does not require the Respondent to propose new/other revenue projects to increase cost-savings.

Date Issued: March 23, 2012

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
Medicare Maximization Request for Proposals

The Department of Social Services (the "Department") is requesting proposals from qualified organizations to perform specific Medicare Maximization (MMX) third party liability (TPL) functions. This **Medicare Maximization Request for Proposals,** (MMX RFP), re-procures the Skilled Nursing Facility, Chronic Disease Hospital, and Home Health Care components of the Department's current MMX Program.

Purpose: This RFP is to enhance and improve upon the Department's TPL System. The RFP has two (2) objectives:

- The MMX contractor will perform specific functions to ensure the Department is payer of last resort if any legally liable third parties exist that are obligated to pay all or part of the cost of a client's health care provided under Connecticut's State Medicaid Plan; and
- The Department wants to generate revenue through the use of a MMX contractor who obtains retroactive Medicare coverage for Medicaid-paid skilled nursing facility, chronic disease hospital, and licensed home health agency services.

Eligibility: The Department seeks proposals from organizations and proposed subcontractor(s), who have no less than five (5) years of demonstrated experience in performing MMX TPL functions as described in the following qualifications.

Qualifications: The Department seeks proposals from organizations and proposed subcontractor(s), who have demonstrated experience in:

- Performing specific functions to ensure the Department is payer of last resort if any legally liable third parties exist that are obligated to pay all or part of the cost of a client's health care provided under Connecticut's State Medicaid Plan;

- Generating revenue through the use of a MMX contractor who obtains retroactive Medicare coverage for Medicaid-paid skilled nursing facility, chronic disease hospital, and licensed home health agency services; and/or

- Performing MMX work on behalf of health insurance companies, Medicare Advantage Plans, Medicare administrative contractors and the like there of.

The resultant contract period is a five-year contract with the option for two one-year extensions at the discretion of the Department and is expected to begin July 1, 2012 and end June 30, 2017.

Respondents planning to respond to this RFP must submit a Letter of Intent (LOI) to the Department no later than 3:00 PM Eastern Standard Time (EST) on March 14, 2012. Proposal submissions must be received in hand, by the Department, no later than 3:00 PM EST on April 11, 2012.

Proposal submissions received after the stated due date and time may be accepted by the Department as a clerical function but will not be evaluated. Proposals that are not evaluated shall be retained for thirty days after the resultant contract is executed, after which the proposals will be destroyed or retained for pick-up by the submitters, upon notification from the Department.

All proposals must be in sealed envelopes or sealed boxes clearly identified as:

Medicare Maximization Request for Proposals

(MMX RFP)

To download this RFP, access the State's Procurement/Contracting Portal at the State of Connecticut Department of Administrative Services' Procurement Services Home Page at **http://das.ct.gov/Director.aspx?Page=12** or call or write:

Marcia McDonough
Department of Social Services
Contract Administration
25 Sigourney Street
Hartford, CT 06106
Telephone: 860-424-5214
Fax: 860-424-5800
E-mail: Marcia.McDonough@ct.gov

The RFP is also available on the Department's website at
http://www.ct.gov/dss/cwp/view.asp?a=2345&q=304920&dssNav=

The Department of Social Services is an Equal Opportunity/Affirmative Action Employer. Questions or requests for information in alternative formats must be directed to the Contract Administration Office at 860-424-5214. Persons who are deaf or hearing impaired may use a Telecommunications Device for the Deaf, (TDD), by calling 1-800-842-4524.

The Department of Social Services reserves the right to reject any and all proposals or cancel this procurement at any time if it is deemed in the best interest of the State.

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SECTION I. BACKGROUND INFORMATION AND PROGRAM OBJECTIVES

A. Overview of the Department of Social Services

The Department provides a broad range of services to older adults, persons with disabilities, families, and persons who need assistance in maintaining or achieving their full potential for self-direction, self-reliance, and independent living. It administers more than ninety legislatively authorized programs and one third of the State budget. By statute, it is the State agency responsible for administering a number of programs under federal legislation including the Rehabilitation Act, the Food and Nutrition Act of 2008, the Older Americans Act, and the Social Security Act. The Department is also designated as a public housing agency for administering the Section 8 program under the federal Housing Act.

The Department is headed by the Commissioner of Social Services and there are two Deputy Commissioners; a Deputy Commissioner for Programs and a Deputy Commissioner for Health Services, Finance, and Administration. There is a Regional Administrator responsible for each of the three service regions. By statute, there is a Statewide Advisory Council to the Commissioner of Social Services and each region must have a Regional Advisory Council.

The Department administers most of its programs through 12 offices located in the three service regions, with central office support located in Hartford. In addition, many services funded by the Department are available through community-based agencies, including the 156 senior centers throughout Connecticut. The Department has out-stationed employees at hospitals to expedite Medicaid applications, and funds Healthy Start sites, which can accept applications for Medicaid for pregnant women and young children. Many of the services provided by the Department are available via mail or telephone call.

There are two entities attached to the Department for administrative purposes only. They are the Child Day Care Council and the Bureau of Rehabilitative Services. The Bureau of Rehabilitative Services is comprised of the former DSS Bureau of Rehabilitation Services; Board of Education and Services for the Blind; Commission on the Deaf and Hearing Impaired; and portions of the Workers' Compensation Commission and Department of Motor Vehicles.

B. OVERVIEW OF THE OFFICE OF QUALITY ASSURANCE

The Office of Quality Assurance (QA) is responsible for ensuring the fiscal and programmatic integrity of all programs administered by the Department. In addition, QA is responsible for ensuring the integrity of all administrative functions of the Department. The office has four separate divisions, each with unique program integrity functions: Audit; Fraud & Recoveries; Quality Control; and Special Investigations.

C. OVERVIEW OF THE DIVISION OF FRAUD & RECOVERIES - THIRD PARTY LIABILITY UNIT

The mission of the Fraud & Recoveries TPL Unit is to maximize the resources available to families and individuals that need assistance by utilizing client TPL resources instead of the Connecticut Medical Assistance Program (CMAP) to pay health care costs, thereby assuring quality, accuracy, efficiency, and effectiveness in the delivery of the Department's' programs. This mission is accomplished by the following:

- An integrated TPL System;
- Aggressive and proactive TPL benefit recovery and cost avoidance;
- Both client and provider fraud is deterred and pursued; and
- Overpayments to providers, grantees, contractors, and clients are reduced or recouped.

In State Fiscal Year 2011 the Fraud & Recoveries TPL Unit oversaw TPL benefit recovery and cost avoidance savings of $320 million from legally liable third parties (including insurance companies and Medicare) who were responsible for paying for the cost of client medical care[i]. The Fraud & Recoveries TPL Unit maintains the Department's TPL System. The TPL System achieves Medicaid Program savings through a combination of the following components:

- Skilled Nursing Facility and Home Health Care MMX
- Identification and verification of client third party liability
- Medicaid claims cost avoidance and post-payment recovery

These TPL operations reduce Medicaid costs and produce revenue, which is returned to the State of Connecticut General Fund. TPL operations reduce Connecticut Medicaid Program costs and ensure the State Medicaid Program is payer of last resort.

CMAP provides benefits defined under Title XIX of the Social Security Act, (Medicaid). The Department Medicaid Management Information System (MMIS) contractor, and HP Enterprises, administers the third party liability claims processing. The MMIS coordinates third party resources by cost avoiding or denying Medicaid claims when TPL is known. In addition to HP Enterprises, the Department uses a TPL vendor to perform the following recovery work:

- Health Insurance and Defense Enrollment Eligibility Reporting System (DEERS) Data Matches;
- Third party benefit recovery to commercial insurance, Medicare, and TRICARE Management Activity (TMA);
- Trauma identification;
- Hospital and skilled nursing facility credit balance/overpayment audits; and
- Other recovery projects, as identified.

Under State law, effective July 1, 2011 the Department was authorized to procure an Administrative Services Organization (ASO) to manage medical services provided to all CMAP clients[ii]. It is envisioned that under contract with the Department, the ASO will provide a range of management services including centralized customer call center services, utilization management, care coordination, intensive care management, quality management, reporting, predictive modeling, health risk assessment, provider profiling and other administrative services.

Clients will access health care through the CMAP network, which is the Department's existing fee-for-service network. Claims will be processed through the Department's MMIS claims processing system.
The Department of Social Services transitioned to an ASO model effective January 1, 2012. The new HUSKY Health program will be implemented for all of the Department's medical assistance recipients. Under this new model, the Department will contract with Community Health Network of CT (CHN) to perform as a medical administrative services organization (ASO). CHN will be responsible for helping to improve clients' care experiences, quality of service and cost-effectiveness. In addition, CHN will provide a broad range of services, such as member referral assistance and appointment scheduling; health education; and intensive care management. It will also be responsible for doing utilization management (i.e., prior authorization), quality management, health data analytics and reporting. However, CHN will neither be at risk for, nor responsible to pay for any medical assistance recipient cost of care for services. Instead, the Department of Social Services will be directly at risk for, and responsible to pay for all cost of care. Health Care providers will receive Medicaid fee-for-service reimbursement by submitting claims to HP Enterprises.

D. PURPOSE OF REQUEST FOR PROPOSALS

The Department of Social Services (the "Department") is requesting proposals from qualified organizations to perform specific Medicare Maximization (MMX) third party liability (TPL) functions. This Request for Proposals (RFP) re-procures the Skilled Nursing Facility, Chronic Disease Hospital, and Home Health Care components of the Department's current MMX Program.

The purpose of this RFP is to enhance and improve upon the Department's TPL System. The RFP has two (2) objectives. First, the MMX contractor will perform specific functions to ensure the Department is payer of last resort if any legally liable third parties exist that are obligated to pay all or part of the cost of a client's health care provided under Connecticut's State Medicaid Plan. Second, the Department wants to generate revenue through the use of a MMX Contractor who obtains retroactive Medicare coverage for Medicaid-paid skilled nursing facility, chronic disease hospital, and licensed home health agency services. Although this RFP Scope of Work addresses MMX for Connecticut's dual eligible population, it is envisioned that through this work skilled nursing facilities, chronic disease hospitals, and licensed home health agencies on a state-wide basis, will increase their knowledge and understanding of appropriate Medicare coverage criteria. This in turn will result in more access to care for all of Connecticut's frail, elderly, and disabled patients.

The RFP seeks to meet these objectives by:

- Continuing and enhancing existing Department Home Health, Skilled Nursing Facility, and Chronic Disease Hospital MMX programs.
- Developing a Root Cause Corrective Action Plan to identify business practices, system deficiencies, or other problems that must be addressed to improve Medicare coordination of benefits amongst the Department, the provider community, the Medicare System, and other stakeholders.

- Developing integrated MMX processes to improve the program quality, integrity and effectiveness of Medicaid TPL coordination of benefits.
- Leveraging and implementing automation and technology, wherever possible, to ensure that MMX program operations between the Department, the provider community, the Medicare System, and other stakeholders are performed most efficiently.

Under this RFP, the Department expects to award one contract to perform all MMX functions described in the scope of work.

The MMX procurement is for an existing function. The Department currently contracts with the Center for Medicare Advocacy, Inc. The current contract will expire on June 30, 2012. To ensure a fair, open, and competitive process, the Department will not disclose the value of the existing contract.

E. QUALIFICATIONS

The Department seeks proposals from organizations and proposed subcontractor(s), who have no less than five (5) years of demonstrated experience in performing the following MMX TPL functions:

- Performing specific functions to ensure the Department is payer of last resort if any legally liable third parties exist that are obligated to pay all or part of the cost of a client's health care provided under Connecticut's State Medicaid Plan;

- Generating revenue through the use of a MMX contractor who obtains retroactive Medicare coverage for Medicaid-paid skilled nursing facility, chronic disease hospital, and licensed home health agency services; and/or

- Performing MMX work on behalf of health insurance companies, Medicare Advantage Plans, Medicare administrative contractors and the like there of.

SECTION II OVERVIEW OF THE PROCUREMENT PROCESS

A. ISSUING OFFICE AND CONTRACT ADMINISTRATION

The Department of Social Services is issuing this RFP through its Office of Contract Administration - Procurement Unit. The Contract Administration - Procurement Unit is the Issuing Office for this procurement and is the only contact in the State of Connecticut for this procurement. The integrity of the procurement process is based in part on ensuring that all potential and intended Respondents be afforded the same information and opportunities regarding the terms of the procurement. Therefore, it is incumbent upon the Issuing Office to monitor, control, and release information pertaining to this procurement. Potential and intended Respondents are advised that they must refrain from calling or writing any other office within the State of Connecticut or any other State employee with questions or comments related to this procurement. Potential and intended Respondents who call or write others within the State of Connecticut with questions or issues pertaining to this procurement may risk disqualification from consideration. Decisions regarding such disqualification will be made by the Department of Social Services' Contract Administrator within the Issuing Office, after consultation with the Office of the Commissioner. The contact information for the Issuing Office is:

Marcia McDonough
Contract Administration
Department of Social Services
25 Sigourney Street, Hartford, CT 06106
Phone: (860) 424-5214 - Fax: (860) 424-5800
E-mail: marcia.mcdonough@ct.gov

All questions, comments, proposals, and other communications with the Issuing Office regarding this RFP must be submitted in writing directed to the Issuing Office and must be clearly identified as pertaining to the:

Medicare Maximization Request for Proposals

(MMX RFP)

Any material received that does not so state its RFP-related contents will be opened as general mail.

B. PROCUREMENT SCHEDULE

Milestones	Ending Dates
RFP Released	**February 29, 2012**
Questions Due 3:00 PM EST	March 14, 2012
Mandatory Letter of Intent (LOI)	March 14, 2012
Responses to Questions (tentative)	March 20, 2012
Proposals Due by 3:00 PM EST	**April 11, 2012**
Successful Respondent Announced	TBD
Contract Negotiations Begin (tentative)	June 1, 2012
Contract Begins	**July 1, 2012**

C. RESPONDENTS' QUESTIONS

The Department will not sponsor a Respondents' Conference with regard to this RFP. Instead, the Department encourages Respondents to submit written questions.

The Department will accept written questions submitted to the Issuing Office by 3:00 PM EST on March 14, 2012. Questions may be submitted to the Issuing Office by facsimile at (860) 424-5800, e-mail at marcia.mcdonough@ct.gov or mail directed to the Issuing Office at the address listed in this RFP. All questions sent by mail or facsimile must also be provided on a disk (Microsoft® Word 6.0, 2003) and received by the Issuing Office by 3:00 PM EST on March 14, 2012. The Department will not respond to questions that do not meet the deadline and criteria listed above. The responses to questions will be presented in an addendum to this RFP and posted by the Department to the DAS State Contracting Portal and the Department's website.

D. MANDATORY LETTER OF INTENT

Interested Respondents **must submit** a Letter of Intent (LOI) to the Issuing Office to advise the Department of its intention to present a proposal in response to this RFP. The LOI should be directed to the Issuing Office by 3:00 PM EST on March 14, 2012. The LOI may be sent via mail, e-mail or fax. **Submission of a LOI is required in order to submit a proposal.**

E. EVALUATION AND SELECTION

The Department will conduct a comprehensive, fair, and impartial evaluation of proposals received in response to this competitive procurement. Only proposals found to be responsive to the RFP will be evaluated and scored. A responsive proposal must comply with all instructions listed in this RFP, including the general proposal format requirements.

F. CONTRACT EXECUTION

The contract developed as a result of this RFP is subject to State contracting procedures for executing a contract, which include approval by the Connecticut Office of the Attorney General. The contract becomes executed only upon the signature of the Office of the Attorney General. No financial commitments may be made by the Department until and unless the contract has been approved by the Office of the Attorney General. The Office of the Attorney General reviews the contract only after the Commissioner of Social Services and the Resultant Contractor have agreed to its provisions and executed the document.

G. ACCEPTANCE OF PROPOSAL CONTENT

The contents of this RFP and the successful Respondent's proposal will form the basis of contractual obligations in the final contract.

The resulting contract will be a Personal Service Agreement (PSA) contract between the successful Respondent and the Department. The Respondent's proposal must include a Statement of Acceptance, without qualification, of all terms and conditions within this RFP and the Mandatory Terms and Conditions for a PSA contract. The Respondent may, however, suggest alternative language to the Mandatory Terms and Conditions. The Department may, after consultation with the Office of the Attorney General, agree to incorporate such alternative language in any resultant contract. The decision whether to incorporate such alternative language, however, rests solely with the Department and the Attorney General; their decision is final.

Any proposal that fails to include the Statement of Acceptance, without qualification, of all terms and conditions within this RFP and the Mandatory Terms and Conditions for a PSA contract may be disqualified as non-responsive.

H. DEBRIEFING / APPEAL / CONTEST OF SOLICITATION OR AWARD

1. Debriefing: After receiving notification from the Department about the outcome of a competitive procurement, any respondent may contact the Issuing Office and request a Debriefing of the procurement process and its proposal. If respondents still have questions after receiving this information, they may contact the Issuing Office 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 Issuing Office.
2. Appeal Process: The Respondent may appeal any aspect of the 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 Procurement Document. Appeals must be submitted by the Respondent to the Agency Head, with a copy to the Issuing Office for the RFP.

Respondents may submit an Appeal to the Department 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. The e-mail sent date or the postmark date on the notification envelope will be considered "day one" of the thirty (30) days.

Following the review process of the documentation submitted, but not later than thirty (30) days after receipt of any such Appeal, a written decision will be issued and delivered to the Respondent who filed the Appeal and any other interested party. The decision will summarize the Department's process for the procurement in question; and indicate the Agency Head's finding(s) as to the merits of the Respondent's Appeal.

Any additional information regarding the Debriefing and/or the Appeal processes may be requested from the Issuing Office for this RFP.

3. Contest of Solicitation or Award: Pursuant to Section 4e-36 of the Connecticut General Statutes, "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..." Refer to the State Contracting Standards Board website at www.ct.gov/scsb.

I. DISPOSITION OF PROPOSALS - RIGHTS RESERVED

Upon determination that its best interests would be served, the Department shall have the right to the following:

1. **Cancellation**: Cancel this procurement at any time prior to contract award.
2. **Amend procurement**: Amend this procurement at any time prior to contract award.
3. **Refuse to accept**: Refuse to accept, or return accepted proposals that do not comply with procurement requirements.
4. I**ncomplete Business Cost Proposal**: Reject any proposal in which the Business Cost Proposal is incomplete or in which there are significant inconsistencies or inaccuracies.
5. **Prior contract default**: Reject the proposal of any Respondent in default of any prior contract with the State or for misrepresentation of material presented in the proposal.
6. **Written clarification**: Require Respondents, at their own expense, to submit written clarification of proposals in a manner or format that the Department may require.
7. **Oral clarification**: Require Respondents, at their own expense, to make oral presentations at a time selected and in a place provided by the Department in order to assist the Department in its determination of the offer of the right to negotiate a contract. The Department reserves the right to limit the number of Respondents invited to make such a presentation. The oral presentation shall be permitted only for the purpose of proposal clarification and not to allow changes to be made to the proposal.
8. **No proposal changes**: Allow no additions or changes to the original proposal after the due date specified herein, except as may be authorized by the Department.
9. **Property of the State**: Own all proposals submitted in response to this procurement upon receipt by the Department.
10. **Separate service negotiation**: Negotiate separately any service in any manner necessary to serve the best interest of the State.

11. **All or any portion**: Contract for all or any portion of the scope of work or tasks contained within this RFP.
12. **Proposal most advantageous**: Consider cost and all factors in determining the most advantageous proposal for the Department when awarding Respondents the right to negotiate contracts.
13. **Technical defects**: Waive technical defects, irregularities, and omissions, if in its judgment the best interests of the Department will be served.
14. **Best and Final Offers**: Seek Best and Final Offers (BAFO) on price from Respondents upon review of the scored criteria. In addition, the Department reserves the right to set parameters on any BAFO it receives.
15. **Unacceptable proposals**: Reopen the procurement process if the Department determines that all proposals are unacceptable.

J. PROPOSAL PREPARATION EXPENSES

The Department assumes no liability for payment of expenses incurred by Respondents in preparing and submitting proposals in response to this procurement.

K. RESPONSE DATE AND TIME

To be considered for review, a proposal must be received by the Issuing Office by the date and time stated in the Procurement Schedule in SECTION II. of this RFP. The Department will not consider a postmark date as the basis for meeting any submission deadline. Respondents should not interpret or otherwise construe receipt of a proposal after the closing date and time as acceptance of the proposal, since the actual receipt of the document 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 the Respondent is not able to deliver the proposal by courier or in person.

Respondents should allow extra time to comply with building security procedures, when hand-delivering proposals.

Proposals shall not be considered received by the Department until they are in the hands of the Issuing Office or another representative of the Office of Contract Administration designated by the Issuing Office.

L. RESPONDENT ASSURANCES AND ACCEPTANCE

1. **Independent Price Determination**: By submitting a proposal and through assurances given in its Executive Summary, the Respondent certifies that in connection with this procurement the following requirements have been met:
   a. Costs: The costs proposed have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such process with any other organization or with any competitor;

b. Disclosure: Unless otherwise required by law, the costs quoted have not been knowingly disclosed by the Respondent on a prior basis directly or indirectly to any other organization or to any competitor;

c. Competition: No attempt has been or will be made by the Respondent to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition;

d. Prior Knowledge: The Respondent had no prior knowledge of the RFP contents prior to actual receipt of the RFP and had no part in the RFP development; and

e. Offer of Gratuities: The Respondent certifies that no elected or appointed official or employee of the State of Connecticut has or will benefit financially or materially from this procurement. Any contract arising from this procurement may be terminated by the State if it is determined that gratuities of any kind were either offered to or received by any of the aforementioned officials or employees from the contractor, the contractor's agent or the contractor's employee(s).

2. **Valid and Binding Offer**: 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.

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

4. **Restrictions on Communications with DSS Staff**: The Respondent agrees that, from the date of release of this RFP until the Department makes a contract offer, it shall not communicate with Department staff on matters relating to this RFP, except as provided herein through the Issuing Office. Any communication by the Respondent with any of the Department's staff relating to this RFP may, at the discretion of the Department, result in disqualification of that Respondent's proposal.

5. **Acceptance of the Department's Rights Reserved**: The Respondent accepts the rights reserved by the Department.

6. **Experience**: The Respondent and any identified subcontractor must have no less than five (5) years experience providing services related to the tasks identified in this RFP. The Respondent also acknowledges and agrees to allow the Department to examine the Respondent's claim with regard to experience by allowing the Department to review the Respondent's and subcontractor's(if applicable) related contracts and/or to interview contracting entities.

7. **Discovery of a Conflict of Interest:** The Respondent certifies that it shall immediately disclose any situation with the Department's Contract Administrator where the Respondent (if selected as the MMX contractor) becomes aware of an existing, potential, or perceived conflict that may compromise its objective provision of services under the resultant contract. The Department's Contract Administrator will determine the necessary remedy.

A blanket assurance statement in the Executive Summary is acceptable to ensure compliance with Section II. L. 1-7.

M. INCURRING COSTS

The Department is not liable for any cost incurred by the successful Respondent prior to the effective date of a contract.

N. FREEDOM OF INFORMATION AND DECLARATION AND PROTECTION OF PROPRIETARY INFORMATION

Due regard will be given to the protection of proprietary information contained in all proposals received; however, Respondents should be aware that all materials associated with this procurement are subject to the terms of the State Freedom of Information Act, Conn. Gen. Stat. §§ 1-200. et seq., and the Privacy Act and all rules, regulations, and interpretations resulting therefrom. The Respondent must provide convincing explanation and rationale sufficient to justify each exception from release consistent with Section 1-210 (b) of the Connecticut General Statutes to claim proprietary exemptions to the disclosure requirements of the Freedom of Information Act. The rationale and explanation must be stated in terms of the prospective harm to the competitive position of the Respondent that would result if the identified material were to be released and the reasons why the materials are legally exempt from release pursuant to the above cited statute.

It will not be sufficient for Respondents to merely state generally that the proposal is proprietary in nature and, therefore, not subject to release to third parties. Information in proposals concerning price and cost alone do not meet exemption requirements. Those particular pages or sections that a Respondent believes to be proprietary must be specifically identified as such.

While Respondents may claim proprietary exemptions, the final administrative authority to release or exempt any or all material so identified rests with the State.

The Proprietary Declaration and rationale must be included in the Executive Summary as noted in SECTION IV. Proposal Contents Part One: Cover Sheet, Executive Summary, and Forms. Respondents may not be given another opportunity to declare proprietary information or provide a detailed rationale.

O. CONFLICT OF INTEREST- Disclosure Statement:

Respondents must include a disclosure statement concerning any current business relationships (within the past three (3) years) that pose a conflict of interest, as defined by C.G.S. § 1-85. A conflict of interest exists when a relationship exists between the Respondent and a public official (including an elected official) or State employee that may interfere with fair competition or may be adverse to the interests of the State. The existence of a conflict of interest is not, in and of itself, evidence of wrongdoing. A conflict of interest may, however, become a legal matter if a Respondent tries to influence, or succeeds in influencing, the outcome of an official decision for their personal or corporate benefit. The Department will determine whether any disclosed conflict of interest poses a substantial advantage to the Respondent over the competition, decreases the overall competitiveness of this procurement, or is not in the best interests of the State. In the absence of any conflict of interest (COI), a Respondent must affirm such in the disclosure

statement. *Example: "[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* **The COI disclosure statement should be included in the Executive Summary.**

P. AFFIRMATIVE ACTION

Regulations of Connecticut State Agencies Section 46a68j-3(10) requires State agencies to consider the following factors when awarding a contract that is subject to contract compliance requirements: the respondent's success in implementing an affirmative action plan; the respondent's success in developing an apprenticeship program complying with Section 46a-68-1 to 46a-68-17 of the Connecticut General Statutes, inclusive; the respondent's promise to develop and implement a successful affirmative action plan; the respondent's submission of EEO-1 data indicating that the composition of its work force is at or near parity when compared to the racial and sexual composition of the work force in the relevant labor market area; and the respondent's promise to set aside a portion of the contract for legitimate small contractors and minority business enterprises.(See CGS 4a-60).

Q. RESULTANT CONTRACT PERIOD, FUNDING, AND NUMBER OF AWARDS

The resultant five-year contract period is expected to begin July 1, 2012 and end June 30, 2017 with the option for two one-year extensions at the discretion of the Department.

It is the Department's intent to award one contract for services described in the RFP. The Department reserves the right to fund more than one contract if desired.

SECTION III PROPOSAL FORMAT REQUIREMENTS

A. GENERAL PROPOSAL FORMAT REQUIREMENTS

Respondents must submit proposals that follow the requirements of this RFP including the requirements of format that have been established in order to facilitate the Department's evaluation process. The proposal format requirements are listed in this section below and the content requirements are listed in Section IV. of this RFP. Respondents must respond to each content requirement that begins with "**To submit a responsive proposal, THE RESPONDENT SHALL"** and those responses must reference the RFP request citation.

1. **Section IV. Proposal Contents - Part One** must contain the Cover Sheet, Executive Summary and Forms.
2. **Section IV. Proposal Contents - Part Two** should demonstrate the Respondent's understanding of and ability to perform the resultant contractor's performance requirements. The Respondent's proposal must present the Respondent's understanding of the program, including how the Respondent proposes to perform the tasks, identify problems, and solve them without a rewriting of the RFP requirements. A responsive proposal shall address each task requirement separately.

   This section must also contain the Respondent's organizational information as it relates to the Respondent's ability to perform the activities as presented in the RFP. It must describe the background and experience of the Respondent's organization, and the Respondent's proposed subcontractors if applicable, and include details regarding its size and resources, staffing and its experience relevant to the functions to be performed under the resultant contract or recent contracts for similar services. Part Two shall also include the Respondent's capabilities in data reporting and technology.

   If the Respondent is proposing a subcontractor to provide requirements of this RFP, information in regard to the subcontractor and those requirements must be provided in those appropriate sections.
3. **Section IV. Proposal Contents- Part Three** must contain the Respondent's cost and financial information.

B. DELIVERY CONDITION – COPIES NECESSARY

The original (clearly marked) and five (5) exact, legible copies of the proposal must be submitted in clearly marked "Medicare Maximization Request for Proposals (MMX RFP)", sealed envelopes or boxes by the deadline. In addition, two (2) exact electronic copies (compact disk or DVD) of the entire proposal in a non-PDF format must be submitted with the original. Any required documents that are not available in electronic format may be excluded from the electronic copy. The electronic copy must be compatible with Microsoft Office Word or Excel, except any items such as pictures or signatures that cannot be converted into Word or Excel.

C. PROPOSAL STRUCTURE

The Department of Social Services has structured the submission requirements into three distinct parts. An acceptable proposal must include the following:

MMX RFP Binder 1 of 2 should contain; One (1) original, five (5) copies and two (2) conforming electronic copies on CD or DVD, which must be compatible with Microsoft Office Word) of proposal labeled MMX RFP Binder 1 of 2 containing**:**

Part One - Cover Sheet, Executive Summary, and Forms

Part Two - Main Proposal Components

MMX RFP Binder 2 of 2 should contain: One (1) original, five (5) copies and two (2) conforming electronic copies on CD or DVD, which must be compatible with Microsoft Office Word) of proposal labeled MMX RFP Cost Binder 2 of 2, which MUST be separate and distinct from the MMX RFP Binder 1 of 2, containing:

Part Three - Business Cost Proposal

D. PROPOSAL CONSTRUCTION REQUIREMENTS

1. Binding of Proposal - Respondents must submit proposals that coincide with the RFP Table of Contents in loose-leaf notebooks. The legal name of the organization must appear on the outside front cover of each binder and on each page of the proposal. Location of the name is at the Respondent's discretion.

2. Tab Sheet Dividers - A tab sheet keyed to the table of contents must separate each major section of each part of the proposal. The title of each major section must appear on the tab sheet.

3. Table of Contents - Each proposal must incorporate a complete Table of Contents in IV Proposal Contents. It is through this Table of Contents that the Department will evaluate conformance to uniform proposal content and format.

4. Cross-referencing RFP and Proposal - All responses must correspond to the specific assigned task number in the RFP and shall follow the sequence order found in the RFP. Each section of the proposal must cross-reference the appropriate section of the RFP that is being addressed. Proposal responses to specific task requirements must reference the RFP request citation. This will allow the Department to determine uniform compliance with specific RFP requirements.

5. Page Numbers - Each page of each part of the proposal must be consecutively numbered in Arabic numerals beginning with the Cover Sheet.

6. Page Format - The standard format to be used throughout the proposal is as follows:
   a. Text shall be on 8½" x 11" paper in the "portrait" orientation.
   b. Text shall be single-spaced.
   c. Font shall be a minimum of twelve (12) point in Arial (not Arial narrow) or Times New Roman (not Times New Roman Condensed) font as used in Microsoft® Word.

d. 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").

e. Graphics may have a "landscape" orientation, bound along the top (11") side. If oversize, graphics may have a maximum of one (1) fold.

f. Graphics may have a smaller text spacing, pitch, and font size.

g. Resumes are considered text, not graphics.

Any proposal that fails to comply with the Proposal Construction Requirements as stated above, will be considered non-responsive, and subject to disqualification.

SECTION IV PROPOSAL CONTENTS

Where the Respondent's response to a specific requirement reflects the Respondent's response to another requirement, the Respondent may cite the other response instead of reproducing it.

Throughout the RFP: If a Respondent is proposing subcontractor(s) to provide requirements of the Request for Proposals, information in regard to the subcontractor(s) and those requirements must be provided in those appropriate sections.

Part One: Cover Sheet, Executive Summary, and Forms

To submit a responsive proposal, THE RESPONDENT SHALL provide responses to Part One in the order specified below.

1. **Cover Sheet -** The original proposal and all copies must include a Cover Sheet, embedded as a hyperlink, completed with the following information about the Respondent (a.-d.).

   a. Full Legal name of the Respondent and address;

   b. Federal Employer Identification Number or Social Security Number;

   c. Name, title, telephone number, fax number, and e-mail address of the individual with the authority to bind the Respondent to sign a contract with the Department; and

   d. Name, title, telephone number, fax number, and e-mail address of the Respondent's principal contact to receive addenda and/or amendments to the RFP and requests for clarification.

2. **Executive Summary -** Provide a high-level summary limited to four (4) single-sided pages or two (2) doubled-sided pages that summarizes the content of the Respondent's proposal, including any subcontractors proposed by the Respondent to provide services of this RFP. The Executive Summary shall include the Respondent's and subcontractor's, if applicable, demonstrated experience of no less than five (5) years performing the following MMX TPL functions:

   - Performing specific functions to ensure the Department is payer of last resort if any legally liable third parties exist that are obligated to pay all or part of the cost of a client's health care provided under Connecticut's State Medicaid Plan;

   - Generating revenue through the use of a MMX contractor who obtains retroactive Medicare coverage for Medicaid-paid skilled nursing facility, chronic disease hospital, and licensed home health agency services; and/or

   - Performing MMX work on behalf of health insurance companies, Medicare Advantage Plans, Medicare administrative contractors and the like there of.

   The Executive Summary must also include the following:

   1) Respondent's blanket assurance statement to ensure compliance with Section II- L. 1-7;

2) The identification of any proprietary information (Section II- N);

3) A statement that any submitted response and cost shall remain valid for one hundred twenty (120) days after the proposal due date or until the resultant contract is executed, whichever comes first;

4) Written assurance to the Department of Social Services from its, (Respondent's and subcontractor's, if applicable), legal counsel that it is qualified to conduct business in the State of Connecticut and is not prohibited by its articles of incorporation, bylaws, or the laws under which it is incorporated from performing the services required under any resultant contract;

5) In the absence of any conflict of interest (COI), a Respondent and subcontractor, if applicable, must affirm such in the disclosure statement, (RFP Section II, O.) *Example: "[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) A statement that the Respondent is/is not a resident of Connecticut

3. **Forms** – The original proposal and all copies must include the following RFP requirements in an appropriately tabbed "Appendices" section of the proposal.

a. Agreement Signatory Acceptance

The Respondent must provide a signed Acceptance Statement, (embedded as a hyperlink) without qualification, of all Mandatory Terms and Conditions. The Terms and Conditions are available on OPM's web site at: http://www.ct.gov/opm/fin/standard_contract.

b. Statutory and Regulatory Compliance

1) Addendum Acknowledgement -Proposals must include the Addendum Acknowledgement(s), which will be placed at the end of any and all addenda to this RFP.

2) **Certification Regarding Lobbying** - **To submit a responsive proposal, THE RESPONDENT SHALL** provide a signed statement to the effect that no funds have been paid or will be paid to 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 awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

3) **Notification to Bidders, Parts I – V (CHRO) - 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. **To submit a responsive proposal, THE RESPONDENT SHALL** complete and submit with Proposal.

4) **Consulting Agreement Affidavit (OPM Ethics Form 5) 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 include a consulting agreement affidavit attesting to whether any consulting agreement has been entered into in connection with the proposal. As used herein "consulting agreement" means any written or oral agreement to retain the services, for a fee, of a consultant for the purposes of (A) providing counsel to a Contractor, vendor, consultant or other entity seeking to conduct, or conducting, business with the State, (B) contacting, whether in writing or orally, any executive, judicial, or administrative office of the State, including any department, institution, bureau, board, commission, authority, official or employee for the purpose of solicitation, dispute resolution, introduction, requests for information or (C) any other similar activity related to such contract. Consulting agreement does not include any agreements entered into with a consultant who is registered under the provisions of C.G.S. Chapter 10 as of the date such affidavit is submitted in accordance with the provisions of C.G.S. § 4a-81. **IMPORTANT NOTE: To submit a responsive proposal, THE RESPONDENT SHALL** complete and submit OPM Ethics Form 5 to the Department with the Proposal.

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 awarded** an opportunity to negotiate a contract with an anticipated value of $50,000 or more in a calendar or fiscal year, the Respondent must fully disclose any gifts or lawful contributions made to campaigns of candidates for statewide public office or the General Assembly. Municipalities and 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 **http://www.ct.gov/opm/fin/ethics_forms** IMPORTANT NOTE: The successful Respondent must complete and submit OPM Ethics Form 1 to the Department prior to contract execution.

6) **Nondiscrimination Certification, C.G.S. §§ 4a-60(a)(1) and 4a-60a(a)(1). If a Respondent is awarded** an opportunity to negotiate a contract, the Respondent must 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 **http://www.ct.gov/opm/fin/nondiscrim_forms** IMPORTANT NOTE: The successful Respondent must complete and submit the appropriate nondiscrimination certification form to the awarding Department prior to contract execution.

7) **Reciprocal Preference Statue and Resident Bidder Status** – The following statute is included in this RFP as information to the Bidder/Respondent: Connecticut Public Act 08-154, embedded as the following hyperlink, PA 08-154 (SB 679), enacted a reciprocal preference statute which states that if a bidder that is not from Connecticut, a "nonresident bidder," bids on a Connecticut procurement, and the bidder comes from a state that disadvantages nonresident bidders by adding a percent increase to the total cost of the out-of-state bidder's proposal, Connecticut state agencies will apply the same percent increase to the nonresident bidder's cost proposal that the home state of the nonresident bidder would apply to a nonresident bidder's cost proposal.

Part Two- Main Proposal Components

Where the Respondent's response to a specific requirement reflects the Respondent's response to another requirement, the Respondent may cite the other response instead of reproducing it.

Throughout the RFP: If a Respondent is proposing subcontractor(s) to provide requirements of the Request for Proposals, information in regard to the subcontractor(s) and those requirements must be provided in those appropriate sections.

A. Organizational Capability and Structure - Maximum page limitation for A. Organizational Capability and Structure is ten (10) single - sided or five (5) double - sided pages.

General - **Responses to the requirements in this section must describe the Respondent's and any proposed subcontractor's** background and experience relevant to Medicare Maximization. The responses must also address the details regarding the Respondent's organization, and resources of the organization. The proposal must clearly describe the Respondent's ability and competence to perform the requirements as described in this RFP.

1. Summary of Organizational Capacity - The Department is requesting proposals from qualified organizations and proposed subcontractor(s), if applicable, to fulfill the Medicare Maximization third party liability functions as directed by the Department.

   A responsive proposal shall demonstrate that the Respondent and any proposed subcontractor(s), if applicable, have no less than five (5) years experience in performing MMX TPL functions as described in the qualification requirements.

   To submit a responsive proposal, THE RESPONDENT SHALL include the following specific details regarding the Respondent and subcontractor, if applicable:

   a. Organization establishment date, mission at time of establishment, the current mission statement, and if the current mission is different from original, a description of the changes in focus that led to the current mission;

   b. Description of how your organization meets the required contractor qualifications of this RFP to include at a minimum:

      1) Performing specific functions to ensure the Department is payer of last resort if any legally liable third parties exist that are obligated to pay all or part of the cost of a client's health care provided under Connecticut's State Medicaid Plan;

      2) Generating revenue through the use of a MMX contractor who obtains retroactive Medicare coverage for Medicaid-paid skilled nursing facility, chronic disease hospital, and licensed home health agency services; and/or

      3) Performing MMX work on behalf of health insurance companies, Medicare Advantage Plans, Medicare administrative contractors and the like there of; and

   c. Explanation as to why your organization is well suited to implement the services required by this RFP.

d. Organization chart showing the hierarchical structure of functions and positions within your organization. Indicate on the diagram where the following functions related to this program will be located, including at a minimum: Program Director, Program Manager, Key Positions to include trained Lawyers, Information Technology staff, Clinical Health Care Professionals, Business Analysts, administrative staff and/or support staff.

2. Governance - Disclosure -**To submit a responsive proposal THE RESPONDENT SHALL** provide the following information about itself as the Respondent and any proposed subcontractors:

   a. The role of the board of directors in governance and policy-making;

   b. The name, work address, and percentage of time allocated for this resultant contract for each board of director;

   c. A current organizational chart defining levels of ownership, governance and management; and

   d. A complete description of any and all related party relationships and transactions. The Respondent must fully disclose any potential conflicts of interest associated with related parties.

3. Ownership - Disclosure -**To submit a responsive proposal THE RESPONDENT SHALL** provide the following information for itself and any proposed subcontractor(s):

   a. A complete description of percent of ownership by the principals of the company or any other individual or organization that retains a 5% or more interest including: name and work address;

   b. The relationship of the persons so identified to any other owner or governor if they are the individual's spouse, child, brother, sister, or parent;

   c. The name of any person with an ownership or controlling interest of 5% or more, in the Respondent, who also has an ownership or control interest of 5% or more in any other related entity including subcontracting entity or parent entity or wholly owned entity. The Respondent shall include the name or names of the other entity;

   d. The name and address of any person with an ownership or controlling interest in the disclosing entity or who is an agent or employee of the disclosing entity who has been convicted of a criminal offense related to that person's involvement in any program under Title XVIII, XIX, XX or XXI of the Social Security Act, since the inception of such programs;

   e. Whether any person identified in subsections a. through d. above has been terminated, suspended, barred or otherwise excluded from participation, or has voluntarily withdrawn as the result of a settlement agreement, from any program under Titles XVIII, XIX, or XX of the Social Security Act, or has within the last five years been reinstated to participation in any program under Titles XVIII, XIX, XX or XXI of the Social Security Act, and prior to said reinstatement had been terminated, suspended, barred or otherwise excluded from participation, or has voluntarily withdrawn as the result of a settlement agreement, in such programs;

   f. A description of the relationship with other entities including:

      1) Whether the Respondent is an independent entity or a subsidiary or division of another company (if the Respondent is not an independent entity, Respondents shall describe the organization linkages and the degree of integration/collaboration between the organizations including any roles of the organization's principals); and

      2) A description of the relationship of any parent company when the Respondent is an affiliate of another organization.

4. Corporate Experience - **To submit a responsive proposal, THE RESPONDENT SHALL:** describe its experience and success related to the Scope of Services for MMX TPL including the following information concerning the Respondent's and any proposed subcontractor's experience with other contracts or projects similar to the type of service contemplated by this RFP, whether ongoing or completed:

   a. Summary of relevant experience to include current range of services the organization provides, relevant to the functions to be performed as required under the resultant contract;

   b. Identify all State agencies and commercial vendors for which the Respondent has engaged in similar or related contract work or projects completed within the last three (3) years with emphasis on activities relevant and related to the proposed program;

   c. Describe the corporate background as it relates to projects similar in scope and complexity to the project described in this RFP. If the proposal includes the use of subcontractors, include a similar description of each subcontractor's corporate background;

   d. Explain whether work was performed as a prime contractor or subcontractor. If the work was performed as a subcontractor, the Respondent must describe the scope of subcontracting activities;

   e. Provide a signed release allowing the Department of Social Services to access any evaluative information including, but not limited to, site reviews conducted by any state agency or commercial vendor for which the Respondent has performed work in the past three (3) years. **NOTE: The signed release must be submitted as a separate sheet and must be located immediately following the Executive Summary located after the Table of Contents.**

   f. Identify contacts for those projects of similar scope including name of customer's project officer, title, mailing address, telephone number, fax number, and e-mail address;

   g. Identify the term for the contracts including the contract signing date, the project initiation date, the initial scheduled completion date, and the actual completion date;

   h. List all contracts awarded to the Respondent or its predecessor firm(s) by the State of Connecticut during the past three years by State Department, Division, Contact Person (with mailing address/telephone number/e-mail address), period of performance and amount; and

   i. List all sanctions, fines, penalties, or letters of noncompliance issued against the Respondent by any of the contracting entities listed above. The list shall describe the circumstance eliciting the sanction, fine, penalty, or letter of noncompliance and the corrective action or resolution to the sanction, fine, penalty, or letter of noncompliance. If no sanctions, fines, penalties, or letters of noncompliance were issued, a statement that attests that no sanction, fine, penalty, or compliance action has been imposed on the Respondent within the three years immediately preceding the RFP posting/release date must be submitted.

5. Respondent References - **To submit a responsive proposal, THE RESPONDENT SHALL** provide three specific programmatic references for the Respondent. References must be persons able to comment on the Respondent's capability to perform the services specified in this RFP. The contact person must be an individual familiar with the organization and its day-to-day performance. If the Respondent has been a State of Connecticut contractor within the past three years, the Respondent must include a State of Connecticut reference. Respondents are strongly encouraged to call or write

their references to ensure the accuracy of their contact information and their willingness and capability to be references. References must include the organization's name, name of a specific contact person, mailing address, telephone number, and e-mail address. The Department of Social Services expects to use these references in its evaluation process and a non-responsive reference may negatively impact a Respondent's score. References cannot be the Respondent's current employees. If the Respondent's submission proposes the use of subcontractors for service provision, the Respondent's proposal must also include three programmatic references for each proposed subcontractor. Respondent References must be included at the end of the Respondent's Organizational Capability and Structure responses. References are not included in the maximum page limitation of this section.

6. Small, Minority, or Women's Business Enterprise - Section 4a-60g of the General Statutes of Connecticut (C.G.S.) sets forth the requirements of each Executive Branch agency relative to the Connecticut Small Business Set-Aside program. Pursuant to that statute, 25 percent of the average total of all contracts let for each of the three previous fiscal years must be set aside. The Department of Social Services requires that if the contractor is utilizing a subcontractor it must make a "Good Faith Effort" to set aside a portion of the resultant contract for a small, minority, or women's business enterprise as a proposed subcontractor. Such proposed subcontractors may supply goods or services. Prospective Respondents may obtain a list of firms certified to participate in the Set-Aside program at the State of Connecticut Department of Administrative Services Web site at http://www.das.state.ct.us/Purchase/SetAside/SAP_Search_Vendors.asp or by calling 860-713-5236. During the evaluation process, special consideration will be given to those Respondents who document their use of a certified small business or show the Respondent's commitment to, whenever possible, use a certified small business. Businesses must be certified with the State of Connecticut. **To submit a responsive proposal, THE RESPONDENT SHALL** describe its effort to set aside a portion of the resultant contract for a small, minority, or women's business enterprise as a proposed subcontractor if it is proposing the use of a subcontractor.

7. Department of Social Services Responsibilities - **To submit a responsive proposal, THE RESPONDENT SHALL** propose specific supports the Respondent requires from the Department of Social Services to perform the tasks in any resultant contract.

   Specific Department of Social Services responsibilities already include:

   a. Project Management - A Project Manager will be appointed by the Department of Social Services. This individual will be responsible for monitoring project progress and will have final authority to approve/disapprove project deliverables.

   b. Staff Coordination - The Project Manager will coordinate all needed contacts between the resultant MMX contractor and Department staff.

   c. Approval of Deliverables - The Project Manager will review, evaluate, and approve all deliverables before the MMX contractor is released from further responsibility.

   d. Policy Decisions - The Department of Social Services retains final authority for making policy decisions affecting completion of the MMX project. In addition, the Department of Social Services shall:

      1) Monitor the MMX contractor's performance and request updates, as appropriate;

      2) Respond to written requests for policy interpretations;

3) Provide technical assistance to the MMX contractor, as needed;

4) Allow access to Department of Social Services automated databases, as available and permitted;

5) Allow access to management reports and case files, as appropriate;

6) Hold regularly scheduled project meetings with the MMX contractor;

7) Provide a process for, and facilitate open discussions with, staff and personnel to gather information regarding recommendations for improvement; and

8) Provide data as required by the MMX contractor to perform the functions of the MMX contract.

An Introduction to the Medicare Maximization Scope of Work, B. Scope of Services, is provided, followed by subsections:

- **B. 1. MMX Respondent and Contractor requirements applicable to both the Skilled Nursing Facility (SNF)/Chronic Disease Hospital (CDH) and Home Health Scope of Work**
- **B. 2. SNF/CDH Specific MMX Respondent and Contractor Requirements**
- **B. 3. Home Health Specific MMX Respondent and Contractor Requirements**
- **B. 4. Other Contractor Requirements - Information only**

Maximum page limitation for subsections: **B.1 - B.3,** is seventy (70) single-sided or thirty-five (35) double-sided pages.

Where the Respondent's response to a specific requirement reflects the Respondent's response to another requirement, the Respondent may cite the other response instead of reproducing it.

Throughout the RFP: If a Respondent is proposing subcontractor(s) to provide requirements of the Request for Proposals, information in regard to the subcontractor(s) and those requirements must be provided in those appropriate sections.

General - Responses for this section must describe the Respondent's and any proposed subcontractor's capability and competence to perform the requirements specified in this RFP.

No Rewrites - The Department of Social Services does not want a rewrite of the RFP requirements, since such a proposal would show a lack of understanding of the program and an inability to provide appropriate levels of support and guidance for the implementation of this type of program. Rather the Department seeks a detailed explanation that indicates how and by what mechanism the Respondent will achieve the requirements set forth in this RFP.

B. Scope of Services

1. Introduction to the Medicare Maximization Scope of Work

The Department would like to ensure that Medicaid clients who are also eligible for Medicare (i.e. Dual Eligible Clients) receive all Medicare benefits to which they are legally entitled under law. Further, the Department recognizes the direct relationship that exists between a Dual Eligible Client that is not fully realizing the Medicare benefit to which they are entitled under law, and a cost shift to CMAP for the needed services. Under Federal regulation and Connecticut General Statute, the Department is mandated to be the payer of last resort if any legally liable third party exists that must pay all, or part of a Medicaid client's services covered under the Medicaid State Plan[iii]. Medicare, as defined under Title XVIII of the Social Security Act, meets the definition of a legally liable third party. The Medicare rights of Connecticut Dual Eligible Clients are subrogated to the Department thereby allowing the state agency or its agent to act in place of these individuals and exercise their Medicare due process rights[iv]. Also, as a condition of Medicaid eligibility, clients agree to let the Department file Medicare claims and pursue Medicare appeals on their behalf, and for the state agency to seek reimbursement for Medicaid paid care directly from his or her insurance company. This RFP is to continue and enhance the Department's current MMX scope of work in exercising Medicare due process rights for the following health care services covered under Connecticut's State Medicaid Plan:

a. Skilled Nursing Facility Services
b. Chronic Disease Hospital Services
c. Licensed Home Health Agency Services

Through this RFP, a MMX contractor will be selected to assist the Department with the identification and recovery of certain Medicaid paid services made by the Department or its agent(s) to various providers for medical services provided to Dual Eligible Clients, which upon Medicare review are likely to receive Medicare coverage. MMX has two program modules: 1) Skilled Nursing Facility and Chronic Disease Hospital (SNF/CDH) and 2) Home Health Care. A description of the Department's current SNF/CDH and Home Health MMX processes follow.

2. Skilled Nursing Facility and Chronic Disease Hospital MMX - Current Process

The Department's Convalescent Payment Unit (CPU) coordinates Medicare and Medicaid benefits for skilled nursing facility and chronic disease hospital services. The CPU requires that these facilities demonstrate that Medicare benefits have been sought and denied before the Department will issue a Medicaid payment for the cost of a client's skilled nursing facility or chronic disease hospital (SNF/CDH) care. The facilities utilize one of the following Medicare documents to demonstrate such denial.

a. A Medicare Remittance Advice
b. A Facility Medicare Denial Notice
c. A Facility Medicare Tracking Log

The Department uses these Medicare documents to file Medicare appeals and obtain Medicare coverage for Medicaid paid SNF/CDH services. The current SNF/CDH MMX Program is a referral based process. The CPU forwards to the SNF/CDH MMX contractor one of the Medicare documents described above. The Contractor obtains the Medicare denial, and to support the filing of a client's Medicare appeal, requests from the facility the following documentation including but not limited to:

1) Hospital Discharge Summary
2) Interagency Referral Form (W10)
3) Medical History and Physical
4) Physicians' Orders
5) Nurses' Notes, Care Plans, Flow Sheets, and Medication Records
6) Medicare Payment Voucher
7) Medicare Notice of Non-Coverage

The Contractor uses this information to file the appropriate Medicare Administrative Appeal: a Request for Payment and Initial Determination of Medicare Coverage, or Request for Redetermination or Reconsideration of Medicare Coverage with the proper Medicare Administrative Contractor or Medicare Advantage Plan. The Contractor files these appeals and pursues Medicare coverage on behalf of the Department's Commissioner. Subsequently, the Contractor reviews these Medicare decisions. For those client SNF/CDH services denied Medicare coverage at the first stages of appeal; the Contractor may continue to exercise the Medicare appeals process and file an Administrative Law Judge Hearing appeal, or an appeal to the U.S. Department of Health and Human Services' Departmental Appeals Board, Medicare Appeals Council.

In State Fiscal Years 2010 and 2011, the SNF/CDH MMX Program generated approximately one thousand three hundred and twenty-one (1,321) Medicare client decisions for a total of twenty-four thousand seven hundred and thirty-two (24,732) Medicaid recoverable room and board days and $5.2 M in Medicaid recoupment. These Medicare client decisions include both Medicare grants of coverage and provider liable decisions holding the nursing facility financially liable for the cost of Medicaid services under Medicare appeal. The Medicare grants of coverage and provider liable decisions averaged, respectively, between fifteen (15) and twenty-two (22) Medicaid recoverable room and board days. Please see Chart 1 below.

Chart 1

Skilled Nursing Facility - Chronic Disease Hospital MMX Experience

State Fiscal Years 2010 and 2011

	Number of Medicare Client Decisions	Medicaid Recoverable R&B Revenue	Medicaid Recoverable R&B Days	Average Medicaid R&B Revenue Per Decision	Average Medicaid Recoverable R&B Days
Medicare Grants of Coverage Decisions	852	$3,027,287	13,777	$3,345	15
Medicare Provider Liable Decisions	469	$2,335,689	10,955	$4,776	22
Total Medicare Grants and Provider Liable Decisions	1321	$5,362,976	24,732	$3,847	18

In the current SNF/CDH MMX scope of work, skilled nursing facilities and chronic disease hospitals may be held financially liable for the Medicaid services under the Medicare appeal; if the facility had either failed to issue a Medicare Notice of Non Coverage or does not have or fails to provide medical documentation necessary for the Medicare Administrative Contractor to formulate a Medicare coverage decision. During State Fiscal Years 2010 and 2011, about forty-four percent (44%) of the Medicaid dollars at issue were subject to recoupment by the Department due to provider liability. This situation is a Root Cause Corrective Action Plan issue. The Department wants to decrease provider financial liability in the MMX Program.

In addition, a beneficiary may be entitled to up to one hundred (100) days of Medicare Part A Skilled Nursing Facility coverage in a defined Medicare benefit period or spell of illness. However, from July 2009 through December 2010, SNF/CDH MMX Medicare grants of coverage obtained, on average, only sixteen (16) out of one hundred (100) days of coverage. In addition, only fourteen percent (14%) of all combined MMX Medicare Grants of Coverage, and additional services determined by the nursing facility to be Medicare-covered in the same spell of illness, obtained from 50 to 100 days of coverage. Please see Chart 2 below. This situation is a Root Cause Corrective Action Plan issue; the Department wants to increase the number of Medicare covered days in MMX grants of coverage.

Chart 2				
Skilled Nursing Facility - Chronic Disease Hospital MMX Experience				
Medicare Covered Days in Benefit Period				
July 2009 - December 2010				
		Number of Medicare Client Decisions	Percent of Total Decisions	Average Number of Room and Board Days Obtained in a Benefit Period [1]
Total SNF/CDH MMX Medicare Decisions		886	100%	18
SNF/CDH MMX Provider Liable Decisions		317	36%	23
SNF/CDH Medicare Grants of Coverage		569	64%	16
Combined MMX Grants of Coverage, and additional servcies determined by nursing facility to be Medicare-covered in the same Medicare Benefit Period: Between 50 to 100 days		125	14%	73
Reference				
1 = Includes Room and Board Days for Medicare Grants of Coverage and/or Provider Liability				

Further, the Department's current Medicare coordination of benefit processes require nursing facilities, after issuing a Medicare Notice of Non-Coverage to a client, to observe the individual's condition over the next thirty (30) day period. This is performed to determine if the client's nursing facility care would further qualify for Medicare coverage. If after 30 days, the facility observes no change in the client's condition, the facility is then required to obtain a Medicare denial from its Medicare Administrative Contractor. Once the facility receives a Medicare denial, it may then seek authorization from the Department to receive Medicaid payment. In the end, the nursing facility may have to wait approximately forty-five (45) to sixty (60) days before they are able to receive Medicaid payment. This situation is a Root Cause Corrective Action Plan issue; the Department wants to decrease the provider time frame for performing Medicare coordination of benefits and obtaining Medicaid payment.

Due to these factors, it is envisioned that through this RFP, a Skilled Nursing Facility/Chronic Disease Hospital MMX Contractor will implement a Root Cause Corrective Action plan to:

a) Decrease the number of SNF/CDH Medicare Administrative Appeal Cases in which the provider may be financially liable for the cost of care;
b) Increase the number of Medicare granted covered days to maximize the one hundred (100) days of Medicare Part A Skilled Nursing Facility coverage in a dual eligible client's Medicare benefit period; and
c) Reduce the time required for a skilled nursing facility or chronic disease hospital to perform Medicare coordination of benefits and receive timely Medicaid payment.

3. Introduction to Home Health Care Medicare Maximization

Licensed home health agencies participating in the Medicare Program are required by Medicare regulations to determine when a patient's care is no longer covered under the Medicare benefit. In meeting this requirement, the home health agency issues the patient a Home Health Advanced Beneficiary Notice (HHABN)[v]. The HHABN transfers the liability for the cost of care from the provider to the patient. If the patient is dual eligible, the provider then seeks Medicaid reimbursement. The Department uses HHABN information to coordinate Medicare and Medicaid benefits.

The Department performs Medicare cost avoidance for home health services[VI]. Effective for dates of service on or after April 1, 2010, Medicaid claims for dual eligible clients must contain: 1) the date the HHABN was issued to the client; and 2) one of the following reasons the home health agency determined the client's care is not Medicare coverable.

a. Client determined to be not homebound; either at the start of care or after Medicare-covered services have been provided.
b. Client not receiving part-time or intermittent services from start of care or following the delivery of Medicare-covered services.
c. Client receiving thirty-five (35) hours per week of Medicare-covered skilled nursing and/or home health aide services combined. Medicaid being billed for additional skilled nursing and home health aide services over 35 hours/week.
d. Nursing, therapy and/or dependent services being provided do not meet Medicare coverage requirements, e.g., nursing visits are for medication pre-pours or the home health aide is not primarily performing hands-on personal care.

Failure to provide this information will cause the home health agency's Medicaid claim to be denied, or Medicare cost-avoided.

4. Home Health Medicare Maximization and the Connecticut Home Care Program for Elders (CHCPE)

Under the auspices of the Department, the CHCPE provides home health and community based services funded under a waiver to the Medicaid program and under a program funded with an appropriation by the State General Assembly. "Home health services" means those medical procedures included in the definition of home health services under the Medicaid program. Home health services provided under the CHCPE are defined in the same way and covered to the same extent as they are under the Medicaid program. "Community based services" includes but is not limited to care management, adult day health services, chore services, companion services, elderly foster care, home delivered meals, homemaker services, laundry services, mental health counseling, respite care, transportation, and personal emergency response systems. These community based services are distinct from and different than the home health care modalities performed by licensed home health agencies.

The CHCPE provides home health services by means of an "Access Agency". The Access Agency is an organization that assists the CHCPE client in receiving home health services by conducting assessments and developing plans of care tailored to the needs of the individual client. The Access Agency is not the provider of services. Instead, it manages, arranges and coordinates necessary client home health services in conjunction with a licensed home health agency. The licensed home health agency (HHA) actually performs the care. The Access Agency and HHA jointly determine those skilled nursing, therapy and/or home health aide services that should be covered by either the Federal Medicare or Connecticut Medicaid programs. As a result, the HHA directly bills either Medicare or Medicaid for the care it provides to the CHCPE client.

The Respondent's MMX model should be cognizant of, and integrate the CHCPE and the relationship Access Agencies have with Connecticut licensed home health agencies in determining if a client's care should be billed to either the Medicare or Medicaid programs.

5. Home Health Care MMX Current Process

The Department's current Home Health MMX Program replaced the state agency's participation in the Centers for Medicare and Medicaid Services Home Health Demonstration Project. The current program is based upon a Medicaid post-payment review and selection process. For each of the first three years of the MMX Program the Department determined that three-thousand (3,000) client cases (per year) would be selected for Medicare appeal, and for year four, (4), two-thousand (2000) client cases would be chosen Based upon these client thresholds, the contractor uses proprietary methods to select Medicaid paid claims most likely to receive Medicare coverage upon Medicare appeal. Client cases are developed and selected for appeal contingent upon client claim diagnosis, quantity and type of skilled and unskilled home health services, and Medicaid dollar amount at issue. Each of the four appeal years represents specific Medicaid-paid service periods for which Medicaid claims were selected for Medicare review. The MMX Program currently has four (4) distinct Medicare appeal years in play with client cases at various stages of the Medicare appeal process. Please see Chart 3 below.

Chart 3
Home Health MMX Program
Medicare Appeal Year Status
As of February 24, 2012

Medicare Appeal Service Year	Number of Cases Selected	T19 $ At Issue	T19 $ Removed From Appeal[1]	Cases Going Forward To Medicare Appeal	T19 $ Going Forward To Medicare Appeal	T19 $ Recoveries YTD	Cases Currently in Medicare Appeal Process	T19 $ In Medicare Appeal Process
Oct2007 - Sept2008	3002	$28,755,110	$4,829,352	2460	$23,925,758	$1,954,315	1391	$10,134,407
Oct2008 - Sept2009	3000	$34,499,945	$3,751,481	2502	$30,748,464	$747,804	1661	$17,168,036
July2010 - Dec2010	3000	$18,353,429	$905,067	2875	$17,448,362	$522,919	2771	$16,435,034
July 2011 - Jan 2012	2000	$11,016,226					2000	$11,016,226

Reference
1 = cases and dollars removed by homebound assessment process or other reasons

The contractor performs and coordinates all MMX procedures with the Department, the home health agency community, the Medicare Administrative Contractor, the Department's fiscal agent, HP Enterprises, and other entities. This includes:

a. Developing and selecting Medicaid client cases for Medicare appeal;
b. Notifying Home Health Agencies (HHAs) of their selected client cases and MMX program responsibilities, and providing detailed instructions to HHAs on needed action to take;
c. Providing customer service with the HHA and Medicare Administrative Contractor to facilitate efficient MMX program processes;
d. Developing and producing all required MMX program reporting for the Department;

e. Taking action on Medicare Initial Determinations of Coverage and filing cases to subsequent levels of appeal;
f. Coordinating HHA medical record flow to the Medicare Administrative Contractor (MAC) necessary for Medicare coverage determination to be performed;
g. Performing regular Medicare and Medicaid TPL training to the HHA community;
h. Providing the HHA community with ongoing assistance and support in making accurate Medicare coverage determinations; and
i. Reporting information to the Department's Medicaid Fiscal, Agent HP Enterprises (HP), necessary for HP to perform Medicaid recovery and produce revenue savings.

Historically, the Department and its contractor have worked with the Connecticut Association for Home Care and Hospice, Inc., and its core group of representative home health agencies to develop and implement Connecticut's MMX home health program. The resulting positive working relationship established between the Department, its contractor, and Connecticut's home health industry is one of the primary reasons for the program's success. It is the intent of this procurement to continue to foster this positive relationship.

The following sections contain requirements of the Respondent and any proposed subcontractor(s), as well as informative Contractor responsibilities. The responses should reinforce the background and experience of the Respondent, as well as any subcontractor(s) proposed to deliver services as proposed by the Respondent.

Maximum page limitation for subsections: **B.1 - B.3,** is seventy (70) single-sided or thirty-five (35) double-sided pages.

B. 1. MMX Respondent and Contractor requirements applicable to **both** the SNF/CDH and Home Health Scope of Work

The MMX efforts will have statewide impact affecting two hundred and thirty (230) skilled nursing facilities, nine (9) Chronic Disease Hospitals, and eighty-two (82) licensed home health agencies, who are active CMAP participating providers. Please see **Attachment 1**, embedded as a hyperlink, listing these Medicaid participating providers.

1. **To submit a responsive proposal, THE RESPONDENT SHALL** describe methods and processes to achieve the following goals:
   a. Enhance and improve upon the Department's current MMX processes;
   b. Obtain a timely recovery of Medicaid paid services pursuant to 42 CFR Subpart D - Third Party Liability; embedded in the following hyperlink: http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-part433-subpartD.pdf
   c. Improve coordination of Medicare and Medicaid benefits for dual eligible clients;
   d. Improve provider billing practices to appropriately pursue Medicare; and
   e. Reduce the provider administrative burden in the MMX process.

2. The Contractor shall utilize all available Medicare appeal procedures provided under 42 CFR § 405 Subpart G and Subpart H, both embedded as hyperlinks, Subpart G—Reconsiderations and Appeals Under Medicare Part A, Subpart H—Appeals Under the Medicare Part B Program, §478 Subpart B, also embedded as a hyperlink, Subpart B—Utilization and Quality Control Quality Improvement Organization (QIO) Reconsiderations and Appeals, or other legal processes to provide legal assistance on behalf of the Department for the purpose of obtaining Medicare coverage for Connecticut dual eligible clients not able to receive Medicare benefits for the following types of services covered by the Medicare and Medicaid programs:

   a. Skilled Nursing Facilities; as defined under 42 CFR § 483, Subpart B--Requirements for Long Term Care Facilities, embedded as a hyperlink, and the Connecticut interChange MMIS Provider Manual, Chapter 7 - Nursing Facilities and ICF/MR, January 1, 2008; embedded in the following hyperlink: https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=ch7_iC_nursinghome_V1.0.pdf&URI=Manuals/ch7_iC_nursinghome_V1.0.pdf

   b. Chronic Disease Hospitals; as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies; embedded as a hyperlink: Hospitals, Child Day Care Centers, Other Institutions

And Children's General Hospitals and the Connecticut interChange MMIS Provider Manual, Chapter 7 - Chronic Disease Hospitals, October 2, 2009

c. Licensed Home Health Agencies; as defined in subsection (d) of section 19a-490 of the Connecticut General Statutes (CGS). Please refer to hyperlink Health Care Institutions, for access to CGS 19a-490.

3. **To submit a responsive proposal, THE RESPONDENT SHALL** demonstrate a strong understanding of the Medicare Administrative Appeals Process provided for under 42 CFR Part 405 Subpart G and Subpart H, and Part 478 Subpart B (provided in the hyperlinks above).

4. **To submit a responsive proposal, THE RESPONDENT SHALL** make evident its understanding of applicable Federal Statute and directives and their impact on the Department's SNF/CDH and Home Health MMX efforts. The Respondent shall describe and evaluate the impact (if any) of the following statutes and directives on the ability of Connecticut dual eligible clients obtaining Medicare coverage for skilled nursing facility, chronic disease hospital, and home health services, which could ultimately shift costs to the CMAP. The Respondent should incorporate the following statutes' and directives' impact into its specific proposals to perform SNF/CDH and Home Health MMX:

   a. Patient Protection and Affordability Act of 2010, or Affordable Care Act (PPACA); The Patient Protection and Affordable Care Act Detailed Summary; embedded in the following hyperlink: **The Health Care Law & You | HealthCare.gov;**

   b. Health Care and Education Reconciliation Act of 2010 (HCERA); embedded in the following hyperlink: **http://www.ncsl.org/documents/health/ppaca-consolidated.pdf;**

   c. Medicare Improvement for Patients and Provider Acts of 2008 (MIPPA); embedded in the following hyperlink**: www.govtrack.us/congress/billtext.xpd?bill=h110-6331***;* and

   d. Medicare Home Health Regulations: Improvement is not required to obtain coverage.

      75 Federal Register 70461, amending 42CFR 409.44, effective January 1, 2011

      You can view 75 Federal Register 70461 on page 90 of the embedded hyperlink**: 70372 Federal Register /Vol. 75, No. 221/Wednesday, November 17...**

5. **To submit a responsive proposal, THE RESPONDENT SHALL** describe other statutes and directives that could positively or negatively affect a beneficiary from obtaining Medicare coverage. A responsive proposal shall describe methods and processes that will address the impact of these other statutes and directives on the ability of a Connecticut dual eligible client to obtain Medicare coverage.

6. **To submit a responsive proposal, THE RESPONDENT SHALL** demonstrate an understanding of the following litigation taken against the Department of Health and Human Services Health Care Financing Administration due to the Federal Government's actions that could limit a dual eligible client from obtaining Medicare coverage for skilled nursing `facility, chronic disease hospital, and home health services. The Respondent shall describe and evaluate the impact (if any) of the following litigation on the ability of Connecticut dual eligible clients obtaining Medicare coverage for skilled nursing facility, chronic disease hospital, and home health services, which could ultimately shift costs to the CMAP. The Respondent should incorporate the litigation's impact into its specific proposals to perform SNF/CDH and Home Health MMX.

   a. Fox v. Bowen (CIVH78541),

b. Grijalva v. Shalala (CIV93711 TUC ACM),

c. Wilson-Coker v. Thompson (No. 3:00CV1312 (CFD) (D. Conn.),

d. Healey v. Shalala (CIV398CV0418 DJS),

e. CTDSS v. Leavitt (No. 399CV2020 (SRU) (D. Conn.),

f. Landers v. Leavitt (No. 3:04CV1988JCH (D. Conn.), and

g. Lormore v. Shalala (No. 3:00CV563(AVC).

7. **To submit a responsive proposal, THE RESPONDENT SHALL** describe other court cases that could positively or negatively affect a beneficiary from obtaining Medicare coverage. A responsive proposal shall describe methods and processes that will address the impact of these other court actions on the ability of a Connecticut dual eligible client to obtain Medicare coverage.

8. **To submit a responsive proposal, THE RESPONDENT SHALL** describe any anticipated administrative work it believes will be required of skilled nursing facilities, chronic disease hospitals, and licensed home health agencies in its proposed SNF/CDH and Home Health MMX models.

9. The Contractor shall assist the Department in Medicaid recovery by providing information to the Department or its agent(s) necessary to recover Medicaid payments made to service providers including: Skilled Nursing Facilities, Chronic Disease Hospitals, Home Health Care Agencies, Access Agencies and/or other service providers resulting from MMX work. The format and timing of this information shall be determined by the Department.

10. In situations where an incorrect, erroneous, or otherwise inaccurate provider Medicaid recoupment occurred as a result of SNF/CDH or Home Health MMX work, the Contractor will be required to provide information to the Department and/or its business agents necessary to refund the provider Medicaid payment.

11 The Contractor shall develop and conduct Medicare TPL coordination of benefits training programs for the skilled nursing facility, chronic disease hospital, and Home Health Care provider communities. The goal of the training programs is to educate the respective provider communities in maximizing a Connecticut Dual Eligible Client's Medicare coverage prior to seeking reimbursement from the CMAP.

To submit a responsive proposal, THE RESPONDENT SHALL describe its experience in the development and presenting of Medicare TPL coordination of benefits training programs as detailed above.

12 The Contractor shall seek to work closely with the Centers for Medicare and Medicaid Services (CMS), the Medicare Administrative Contractors, and Medicare Advantage Plans to work through any problems that may develop, either through CMS action or through bottlenecks created by the Medicare Administrative Contractor (MAC) or Medicare Advantage Plans. If the issues cannot be resolved through discussion, the Contractor shall assist the Department to take further action to resolve any MMX program problems, including but not limited to litigation.

B. 2. Skilled Nursing Facility/Chronic Disease Hospital Specific MMX Respondent and Contract Requirements.

1. **To submit a responsive proposal, <u>THE RESPONDENT SHALL</u>** propose a Skilled Nursing Facility and Chronic Disease Hospital MMX (SNF/CDH MMX) Program based upon the Department's current SNF/CDH MMX model as described in Section IV, Part Two, B. Scope of Services 2. Skilled Nursing Facility and Chronic Disease Hospital MMX - Current Process

2. **To submit a responsive proposal, <u>THE RESPONDENT SHALL</u>** describe how its SNF/CDH MMX Model will enhance and improve the Department's current Skilled Nursing Facility and Chronic Disease Hospital Program.

3. **To submit a responsive proposal, <u>THE RESPONDENT SHALL</u>** describe its methods and processes to achieve the following goals under its SNF/CDH MMX model:
   a. Obtain an optimum recovery of Medicaid paid services;
   b. Obtain a timely recovery of Medicaid paid services;
   c. Improve coordination of Medicare and Medicaid benefits for dual eligible clients;
   d. Improve provider billing practices; and
   e. Reduce the provider administrative burden in the Medicare appeal process.

4. **To submit a responsive proposal, <u>THE RESPONDENT SHALL</u>** describe how it will integrate its proposed SNF/CDH MMX processes into a seamless MMX Model, and explain how it will address the RFP's Root Cause Corrective Action requirements:
   a. Increase the number of Medicare covered days for Medicaid services under Medicare appeal,
   b. Decrease the skilled nursing facility and chronic disease hospital financial liability exposure in a SNF/CDH MMX Program, and
   c. Decrease the skilled nursing facility and chronic disease hospital time required to coordinate Medicare and Medicaid benefits.

5. **To submit a responsive proposal, <u>THE RESPONDENT SHALL</u>** explain Medicare coordination of benefits work it has performed on behalf of state Medicaid Programs, health insurance companies, health insurance third party administrators and/or other entities.

6. **To submit a responsive proposal, <u>THE RESPONDENT SHALL</u>** describe obstacles and problems it has encountered performing SNF/CDH MMX work for state Medicaid Agencies, health insurance companies, health insurance third party administrators, or other entities and the business solutions it implemented to mitigate the problems.

7. **To submit a responsive proposal, <u>THE RESPONDENT SHALL</u>** demonstrate a strong understanding of the Medicare Administrative Appeals Process and Medicare coverage requirements for Medicaid Part A - Skilled Nursing Services .

8. **To submit a responsive proposal, THE RESPONDENT SHALL** describe its established business relationships with the U.S. Centers for Medicare and Medicaid Services (CMS), CMS Medicare Administrative Contractors, and Medicare Advantage Plans applicable to performing SNF/CDH MMX.

9. **To submit a responsive proposal, THE RESPONDENT SHALL** describe the conditions under its proposed SNF/CDH MMX model in which a Skilled Nursing Facility or Chronic Disease Hospital could be determined financially liable for the Medicaid services under Medicare appeal.

10. **To submit a responsive proposal, THE RESPONDENT SHALL** include a narrative description and flow chart explaining how its SNF/CDH MMX model (including the use of subcontractors) will function. The description and flow chart should depict operational procedures, roles and responsibilities affecting all stakeholders including but not limited to:
    a. The Medicare-Medicaid client;
    b. The Department as the State Medicaid Agency;
    c. The Department's Business Agents;
    d. Skilled nursing facilities and chronic disease hospitals; and
    e. Medicare Administrative Contactors and Medicare Advantage Plans.

11. **To submit a responsive proposal, THE RESPONDENT SHALL** demonstrate the SNF/CDH MMX model's automated, electronic and efficient processes, for the purpose of limiting the administrative burden and unnecessary work on the affected stakeholders in the health care system: the Medicare-Medicaid client; the Skilled Nursing Facility/Chronic Disease Hospital provider community; the Department as the State Medicaid Agency; the Medicare Program; and other potential entities.

12. **To submit a responsive proposal, THE RESPONDENT SHALL** describe the differences in its SNF/CDH MMX model between dual eligible clients in the traditional Medicare program and those in Medicare Advantage Plans. The Respondent should explain any general or specific problems it has encountered pursuing Medicare coverage in those two different Medicare environments and what remedies it used to eliminate the problems.

13. **To submit a responsive proposal, THE RESPONDENT SHALL** describe how it will increase the number of Medicare covered SNF/CDH days and decrease the SNF/CDH provider liability.

14. **To submit a responsive proposal, THE RESPONDENT SHALL** provide and explain case examples of Skilled Nursing Facility and Chronic Disease Hospital care that it believes would and would not be covered under the Medicare Part A Skilled Nursing Facility benefit.

15. **To submit a responsive proposal, THE RESPONDENT SHALL** explain the success it has had utilizing the Medicare Administrative Appeals Process in obtaining Skilled Nursing Facility and Chronic Disease Hospital Medicare coverage at the different levels of appeal: Initial Determination; Redetermination; Reconsideration; Administrative Law Judge Hearing; and Department Appeals Board Medicare Appeals Council.

16. **To submit a responsive proposal, THE RESPONDENT SHALL** explain differences it believes exist between the Medicare Administrative Contractor, Medicare Advantage Plans, Administrative Law Judge and Department Appeals Board regarding the interpretation of Medicare Part A Skilled Nursing

Facility Services under Federal Medicare Regulations, the Medicare Policy Manual, Local Coverage Determinations (LCDs) or other criteria that can positively or negatively affect a Medicare beneficiary's obtaining Medicare coverage. The Respondent should integrate those ideas into its SNF/CDH MMX Model.

17. **To submit a responsive proposal, THE RESPONDENT SHALL** propose and describe methods and processes to file a Medicare appeal to maximize a dual eligible client's: 1) Medicare Post Hospital SNF Care defined under Medicare regulations at 42 CFR Subpart C - § 409.20 Post Hospital SNF Care Coverage, embedded as a hyperlink, §409.20, and 2) Chronic Disease Hospital care as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies .

18. **To submit a responsive proposal, THE RESPONDENT SHALL** describe how it will integrate activities and communication between the affected stakeholders in the health care system: the Medicare-Medicaid client; the Skilled Nursing Facility/Chronic Disease Hospital provider community; the Department as the State Medicaid Agency; the Medicare Program; and other potential entities, in pursuing an Initial Determination, Redetermination, Reconsideration, Administrative Law Judge Hearing and Department Appeals Board Medicare Appeals Council decision of Medicare coverage.

19. **To submit a responsive proposal, THE RESPONDENT SHALL** describe its role performing the Medicare Administrative Appeals Process on behalf of the client, or as subrogee to the client's Medicare rights.

20. **To submit a responsive proposal, THE RESPONDENT SHALL** project the number of skilled nursing facility and chronic disease hospital cases that will be selected for appeal on a monthly, quarterly, and/or annual basis. The proposal shall explain how the number of SNF/CDH cases was determined.

21. **To submit a responsive proposal, THE RESPONDENT SHALL** propose a skilled nursing facility and chronic disease hospital Medicare - Medicaid coordination of benefits education and training program.

22. The contractor will be required to report all necessary information to the Department and/or its business agents necessary to account for, and recover the following Medicaid paid services as a result of Medicare Part A coverage obtained for skilled nursing facility and chronic disease services:

    a. Skilled Nursing Facility or Chronic Disease Hospital Room and Board Services;
    b. Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology; and
    c. Drugs, biologicals, supplies, appliances and/or equipment.

23. The contractor may be required to report information to the Department and/or its business agents necessary to update client information as a result of Medicare Part A coverage obtained for SNF and CDH services.

24. The contractor will be required to report all necessary information to the Department and/or its business agents necessary for a provider to receive Medicaid reimbursement as a result of a change in a Medicare Part A skilled nursing facility or chronic disease hospital coverage decision, which either

reverses or reduces Medicare coverage, or does not hold the provider liable for the cost of care, or otherwise makes the Connecticut Medicaid Program at risk for the cost of care.

25. The contractor shall be responsible for the follow-up research and determination if its SNF/CDH MMX Model should be performed for dual eligible clients residing in skilled nursing facilities or chronic disease hospitals that are in bankruptcy, reorganization, dissolution, receivership, change in ownership or other change in business condition.

26. The contractor shall coordinate performing SNF/CDH MMX for dual eligible clients residing in Skilled Nursing Facilities or Chronic Disease Hospitals going through changes in business conditions with appropriate Department business units and/or the State of Connecticut Office of the Attorney General.

27. The SNF/CDH MMX Contractor processes to perform this work are dynamic. Throughout the term of this contract the SNF/CDH MMX Contractor may be required to alter its processes. The Medicare coordination of benefits and recovery efforts expected through this contract shall require ongoing collaboration and discussion between the Department and the Contractor with the mutual understanding that the specific process mechanisms employed by the Department and the Contractor may change throughout the term of the contract.

B.3. Home Health MMX Specific Respondent and Contractor Requirements

1. **To submit a responsive proposal, <u>THE RESPONDENT SHALL</u>** propose a Home Health MMX (HH MMX) model based on the Department's current Medicaid Post-Payment HH MMX model.

2. **To submit a responsive proposal, <u>THE RESPONDENT SHALL</u>** explain any previous HH MMX work it has performed on behalf of state Medicaid Programs, health insurance companies, health insurance third party administrators and/or other entities.

3. **To submit a responsive proposal, <u>THE RESPONDENT SHALL</u>** include a narrative description and flow chart explaining how its HH MMX model (including the use of subcontractors) will function. The description and flow chart should depict operational procedures, roles and responsibilities affecting all stakeholders including but not limited to:
   a. The Medicare-Medicaid client;
   b. The Department as the State Medicaid Agency;
   c. The Department's Business Agents;
   d. Home Health Care Agencies;
   e. Connecticut Homecare Program Access Agencies;
   f. Medicare Administrative Contactors and Medicare Advantage Plans; and
   g. Other entities.

4. **To submit a responsive proposal, <u>THE RESPONDENT SHALL</u>** describe how it will integrate its proposed HH MMX processes into a seamless MMX Model.

5. **To submit a responsive proposal, THE RESPONDENT SHALL** describe how its HH MMX Model will enhance and improve the Department's current Medicaid Post-Payment MMX program.

6. **To submit a responsive proposal, THE RESPONDENT SHALL** describe obstacles and problems it has encountered performing post-payment MMX program work for state Medicaid Agencies, health insurance companies, health insurance third party administrators, or other entities and the business solutions it implemented to mitigate the problems.

7. **To submit a responsive proposal, THE RESPONDENT SHALL** describe and propose methods and processes to file a Medicare appeal to maximize a dual eligible client's Medicare Home Health benefit for Home Health services defined under Medicare regulation 42 CFR § 409 Subpart E, embedded as a hyperlink for your convenience, **Subpart E - Home Health Services Under Hospital Insurance**:

   a. Skilled nursing services;

   b. Home health aide services;

   c. Physical therapy services;

   d. Speech-language pathology services;

   e. Occupational therapy services; and

   f. Durable medical equipment and medical supplies.

8. **To submit a responsive proposal, THE RESPONDENT SHALL** describe how the Medicaid Post-Payment MMX Model work shall result in a high quality recovery methodology that will identify and target on a statewide basis the highest number of dual eligible clients for Home Health services from the largest amount of Home Health providers that are most likely to receive Medicare coverage.

9. **To submit a responsive proposal, THE RESPONDENT SHALL** describe its established business relationships with the U.S. Centers for Medicare and Medicaid Services (CMS), CMS Medicare Administrative Contractors and Medicare Advantage Plans, and Connecticut's Home Health provider community applicable to performing HH MMX.

10. **To submit a responsive proposal, THE RESPONDENT SHALL** describe the proposed Medicaid Post-Payment MMX Model's automated, electronic and efficient processes for the purpose of limiting the administrative burden and unnecessary work on all affected stakeholders.

11. **To submit a responsive proposal, THE RESPONDENT SHALL** describe the differences in its Medicaid Post-Payment MMX Model scope of work between dual eligible clients in the traditional Medicare program and those in Medicare Advantage Plans.
    The Respondent should explain any general or specific problems it has encountered pursuing Medicare coverage in those two different Medicare environments and what remedies it used to eliminate the problems.

12. **To submit a responsive proposal, THE RESPONDENT SHALL** explain differences it believes exists between the Medicare Administrative Contractor, Medicare Advantage Plan, Administrative Law Judge and Department Appeals Board regarding the interpretation of Medicare Part A Home Health Services under Federal Medicare Regulations, the Medicare Policy Manual, Local Coverage

Determinations (LCD's) or other criteria, which adversely or positively affect a Medicare beneficiary's obtaining Medicare coverage. The Respondent should integrate those ideas into its HH MMX Model.

13. The contractor will be required to report all necessary information to the Department and/or its business agents necessary to account for, and recover the following Medicaid paid services as a result of Medicare Part A coverage obtained for Home Health Services:

    a. Nursing Services;

    b. Home Health Aide Services;

    c. Physical Therapy Services;

    d. Occupational Therapy Services;

    e. Speech-Language Pathology Services;

    f. Durable Medical Equipment; and

    g. Medical Supplies

14 The contractor shall be responsible for the follow-up, research and determination if its HH MMX model should be performed for dual eligible clients receiving services from Home Health providers that are in bankruptcy, reorganization, dissolution, receivership, change in ownership or other change in business condition.

15. The contractor shall coordinate performing HH MMX work for dual eligible clients receiving services from Home Health providers going through changes in business conditions with appropriate Department business units and/or the State of Connecticut Office of the Attorney General.

16. The Medicaid Post-Payment MMX Contractor processes to perform this work are dynamic. Throughout the term of this contract the contractor may be required to alter its processes. The Medicare coordination of benefits and recovery efforts expected through this contract shall require ongoing collaboration and discussion between the Department and the contractor with the mutual understanding that the specific process mechanisms employed by the Department and the contractor may change throughout the term of the contract.

17 The contractor will be required to report all necessary information to the Department and/or its business agents necessary for a provider to receive Medicaid reimbursement as a result of a change in a Medicare Part A Home Health coverage decision that either reverses or reduces Medicare coverage, or does not hold the provider liable for the cost of care, or otherwise makes the Connecticut Medicaid Program at risk for the cost of care.

18. **To submit a responsive proposal, <u>THE RESPONDENT SHALL</u>** propose a Home Health Medicare - Medicaid coordination of benefits education and training program.

B.4. Other Contractor Requirements - Information only

1. At the Department's discretion, the contractor may be required to perform a Commercial Health Insurance Maximization Program. The Department envisions that this Commercial Health Insurance Maximization Model would utilize all available health insurance appeal processes provided under the Connecticut General Statutes listed below, other legal basis, and/or operational procedures for the purpose of obtaining health insurance coverage for health care services covered under Connecticut's Medicaid State Plan.

    a. Title 38a – Insurance, Section 38a-226c., Utilization review company minimum standards: Determinations, notification, appeals and expedited review. Reports to commissioner. Penalties. Regulations.
    b. Title 38a – Insurance, Section. 38a-478m., Internal grievance procedure. Notice re procedure and final resolution. Penalties. Fines allocated to Office of the Healthcare Advocate.
    c. Title 38a – Insurance, Section 38a-501.,(Formerly Sec. 38-174x). Long-term care policies.

2. At the Department's discretion, the contractor may be required to perform a Medicare Compliance Review Program (MCRP) for Skilled Nursing Facility/Chronic Disease Hospital and Home Health care services. The purpose of the MCRP would be to: 1) Ensure that Connecticut Medicaid skilled nursing facility, chronic disease hospital and Home Health providers are making good Medicare coverage decisions at initial start of care and at changes in client health care status over the continuum of care; and 2) Increase Medicare "hidden cost avoidance" by directing billable services to the Medicare Program.

3. At the Department's discretion, the contractor may be required to perform a Medicare contemporaneous, real-time coordination of benefits program for Skilled Nursing Facility/Chronic Disease Hospital and Home Health Care services for the purpose of maximizing Medicare coverage at a dual eligible client's initial access to care and at different health care milestones in a client's continuum of care, and to reduce costs traditional Medicare Maximization initiatives may have on Connecticut's health care delivery system.

4. As a result of either new Federal or State regulation, statute, and/or policy, or changes made to existing regulation, statute, and/or policy, the contractor may be required to either change, modify, or operate differently from the methods it proposed in its RFP response to perform Skilled Nursing Facility/Chronic Disease Hospital and Home Health Care Medicare Maximization work.

C. Staffing Requirements

Where the Respondent's response to a specific requirement reflects the Respondent's response to another requirement, the Respondent may cite the other response instead of reproducing it.

Throughout the RFP: If a Respondent is proposing subcontractor(s) to provide requirements of the Request for Proposals, information in regard to the subcontractor(s) and those requirements must be provided in those appropriate sections.

Maximum page limitation is ten (10) single - sided or five (5) double - sided pages.

Job descriptions, resumes, and references are not included in the page limitation.

General - Responses for this section must describe the Respondent's and any proposed subcontractor's staffing as required in this RFP.

1. Key Positions - The term "Key Positions" refers to the positions related to key personnel who are responsible for the functions to perform the duties as described in the RFP, providing TPL functions to Skilled Nursing Facility, Chronic Disease Hospital, and Licensed Home Health Agency MMX Programs.

   To submit a responsive proposal, THE RESPONDENT SHALL propose Key Positions and/or subcontractor Key Positions related to the personnel responsible for the functions identified in this RFP, and to demonstrate that it has the necessary personnel resources to perform and meet the RFP's goals and objectives.

At a minimum, the following Key Positions should be proposed:

a. **Program Director**
   Responsible for overall operation and success of the MMX Program

b. **Program Manager**
   Responsible for day-to-day management of the MMX Program

c. **Trained Lawyer(s)**
   Experienced and knowledgeable in regulations and policies of the federal Medicare and Medicaid programs, and the Medicare Administrative Appeals Process

d. **Experienced Business Professionals,** to provide, at a minimum, the following services:

   1) Information Technology Services
      Expertise in Medicare and Medicaid claims processing, data collection and analysis

   2) Clinical Health Care Professional Services
      Expertise in review of medical records to determine Medicare coverage. Clinical health care professional staff may include, but not be limited to: licensed Medical Doctors, Advanced Practice Registered Nurses, Nurse Practitioners, physical therapists, occupational therapists, and speech/language therapists

3) Business Analyst Services
Expertise in the understanding of Medicare policy, rules and regulations; Medicare billing and claim submission procedures process

2. **To submit a responsive proposal, THE RESPONDENT SHALL** describe the contract-related experience, credentials, education and training, and work experience required in job descriptions for the proposed key positions and in the resumes for key personnel proposed to fill the key positions and include:

   a. Experience with Respondent;

   b. Experience working in this type of activity;

   c. Education, experience, and training to perform assigned duties relevant to the requirements of the MMX RFP;

3. **To submit a responsive proposal, THE RESPONDENT SHALL** provide an organization chart showing anticipated lines of authority (reporting relationships) of the program staff proposed for the MMX Program. Submit a staffing plan that includes current staff and the percent of time each key position proposed will work on the MMX Program or when your organization will hire staff and orient them to your organization, the MMX Program, and their roles and responsibilities.

4. **To submit a responsive proposal, THE RESPONDENT SHALL** provide three references for each key personnel that will be responsible for the operation and success of the MMX Program: Names, positions, titles, telephone numbers and e-mail addresses of persons able to provide information concerning the proposed key personnel's experience and competence.

   Resumes for key personnel proposed to fill the key positions are limited to two pages per resume. Respondents must incorporate job descriptions, resumes, and references into an appropriately tabbed "Appendices" section of the proposal.

   The resultant contractor must receive the written approval of the Department for changes in key personnel prior to such changes being made. The resultant contractor shall submit to the Department for its approval, the name and credentials of any persons who are proposed to replace existing or previously proposed program management staff, or other key personnel identified by the State. These changes must not negatively impact the Department or adversely affect the ability of the contractor to meet any requirement or deliverable set forth in this RFP and/or the resultant contract.

D. Reporting and Technology Requirements

Where the Respondent's response to a specific requirement reflects the Respondent's response to another requirement, the Respondent may cite the other response instead of reproducing it.

Throughout the RFP: If a Respondent is proposing subcontractor(s) to provide requirements of the Request for Proposals, information in regard to the subcontractor(s) and those requirements must be provided in those appropriate sections.

Maximum page limitation is ten (10) single - sided or five (5) double - sided pages.

General - Responses for this section must describe the Respondent's and any proposed subcontractor's capability and competence to perform the requirements specified in this RFP.

1. A requirement of the contractor will be to provide various reports to the Department. The format and timing of the reports shall be determined by the Department. At a minimum, the contractor shall be required to provide a report on the following:
   a. The MMX experience that occurred during the previous quarter;
   b. The amount of Medicare coverage obtained in an appeal or the services for which the provider is financially liable at each stage of the appeal process;
   c. Medicare recovery determinations by type of service or procedure, time period, quantity of services or procedures, and Medicaid dollars;
   d. Service provider cases that have been selected for Medicare appeal;
   e. Service provider cases that have been withdrawn from the Medicare appeals process stating the date the case was closed and the reason for its closure; and
   f. Service provider cases that have been closed at each level of the Medicare appeals process.

2. The contractor may be required to provide reports or other information to the service providers including: Skilled Nursing Facilities; Chronic Disease Hospitals; Home Health Care Agencies; Access Agencies; and/or ancillary service providers necessary for the providers to balance and reconcile their Medicaid payments with Medicare reimbursement garnered from this program.

3. A requirement of the MMX RFP is to meet the objectives of leveraging and implementing automation and technology, wherever possible, to ensure that MMX program operations between the Department, the provider community, the Medicare System, and other stakeholders are performed most efficiently. **To submit a responsive proposal, THE RESPONDENT SHALL** include the following:

   a. A description of its information system hardware and software that will be used to meet its RFP response to the Skilled Nursing Facility, Chronic Disease Hospital, and Licensed Home Health Agency MMX program requirements;

   b. An explanation of how its information system capabilities will adequately meet its RFP response to the Skilled Nursing Facility, Chronic Disease Hospital, and Licensed Home Health Agency MMX program requirements;

c. A description of how it will use automation and/or technology to increase the efficiency of the Department's current MMX model;

d. A description of what MMX functions will be improved and made more efficient through its use of automation and technology;

e. A description of how it will use automation and/or technology to support skilled nursing facility, chronic disease hospital and licensed home health agency anticipated administrative work, required in its MMX model, as described in Section B. 1. 8 of this RFP;

f. A description of a proposed reporting system that identifies all client Medicare appeal activity for each type of service. The Respondent shall describe how its reporting methodology will allow the Department to know all aspects and status of a client's Medicare appeal; and

g. A description of a proposed reporting methodology that will allow the Department to recover Medicare covered – Medicaid paid services from health care providers for the respective types of service.

    1) For SNF/CDH services, the Respondent shall describe how it will report to the Department any and all services specified in B. 2. 22. of this RFP.

    2) For Home Health services, the Respondent shall describe how it will report to the Department any and all services specified in B. 3. 13. of this RFP.

E. Subcontractors: If the Respondent is proposing the use of any subcontractors to provide any of the services required by this RFP, each subcontractor must be identified in the proposal. All subcontractors are subject to the Department's prior approval. Information that is requested about the Respondent must also be provided about each subcontractor where indicated throughout the RFP.

To submit a responsive proposal <u>THE RESPONDENT SHALL</u> include the following information about each proposed subcontractor.

a. Legal Name, Address, Federal Employer Identification Number (FEIN)

b. Contact Person Name, Title, Telephone Number, Fax Number, E-mail Address

c. Services to be provided

d. Subcontract Agreement Term

e. A sample subcontract shall be included <u>in an appropriately tabbed</u> "Appendices" section of the proposal.

f. A Letter of Intent, (A written statement expressing the intention of the undersigned to enter into a formal agreement, especially a business arrangement or transaction), from each subcontractor indicating intent to perform the services to be provided throughout the entire contract period. Please include the Letter of Intent <u>in an appropriately tabbed</u> "Appendices" section of the proposal.

Part Three - Business Cost Proposal

Throughout the RFP: If a Respondent is proposing subcontractor(s) to provide requirements of the Request for Proposals, information in regard to the subcontractor(s) and those requirements must be provided in those appropriate sections.

Content Requirements: Separate Business (COST) Section

1. **To submit a responsive proposal THE RESPONDENT SHALL** include an original Part Three (clearly marked) and five (5) copies submitted in **a separate binder** from Part One and Part Two properly marked **"Part Three Medicare Maximization Business Cost Proposal"**.

   No cost information or other financial information may be included in any other portion of the proposal. Any proposal that fails to adhere to this requirement may be disqualified as non-responsive. Each proposal must include cost information and other financial information in the following order.

2. **To submit a responsive proposal, THE RESPONDENT SHALL** provide:

   Audited Financial Statements for each of the past two fiscal years. If audited financial statements for each of the past two fiscal years are not available, the Respondent shall provide comparable statements that will document the financial stability of the Respondent and include an explanation of the submission of documents other than audited financial statements.

3. Business Cost Proposal

   a. Per Case Cost and Training Program Cost:

      The cost proposal must contain a per case cost for Skilled Nursing Facility and Chronic Disease Hospital MMX work and a per case cost for Home Health MMX work. The per case cost should be all inclusive of the Respondent's proposal responses in RFP sections: B. Scope of Services, C. Staffing Requirements, D. Reporting and Technology Requirements, and E. Subcontractor costs.

      The cost proposal must also contain an individual Training Program cost for the Respondent's proposal response in RFP sections B. 1. 11, MMX Respondent and Contractor requirements applicable to both the SNF/CDH and Home Health Scope of Work, B. 2. 21, Skilled Nursing Facility/Chronic Disease Hospital Specific MMX Respondent and Contract Requirements, and B.3. 18, Home Health MMX Specific Respondent and Contractor Requirements.

      The following hyperlink, (i.e. Chart 4, MMX RFP: Part Three - Business Cost Proposal, MMX Business Cost Template), MMX Business Cost Template, is to be used by the Respondent to provide its Skilled Nursing Facility and Chronic Disease Hospital and Home Health per case costs, and individual Training Program costs.

      Please know the SFY 2011 Medicare Appeal and Training Program quantities are included for cost proposal calculation purposes only, and are not a reflection of future anticipated case loads or training programs. Please use the SFY 2011 information provided to propose your annual budget as

described below:

b. Annual Cost and Cost for the proposed Five-Year Contract Term:

To submit a responsive proposal, THE RESPONDENT SHALL provide an annual budget (for each of the five years of the proposed contract term) for the tasks described in the Scope of Services, Staffing, Data Technology and Reporting, and Subcontractor sections. Please input your proposed costs into the **blue area** of the MMX Business Cost Template. This information will automatically calculate the Respondent's proposed per case and training program costs for each contract year and for the total five-year contract period, as required in the RFP submission.

c. Cost Narrative:

To submit a responsive proposal, THE RESPONDENT SHALL detail how costs included in the MMX Business Cost Template were calculated. Either Microsoft Office Word or Excel format is acceptable.

Part Four - Proposal Evaluation

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 contracts, the Department will conform to its written procedures for PSA procurements (pursuant to C.G.S. § 4-212-4-219, inclusive, related to Personal Service Agreements) and the State's Code of Ethics (pursuant to C.G.S. §§ 1-84 and 1-86).

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

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

4. **Evaluation Criteria.** Proposals meeting the Minimum Submission Requirements will be evaluated according to the established criteria. The criteria are the pre-established objective standards that the Evaluation Team will use to evaluate the technical and financial 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 kept confidential from the Evaluation Team to ensure that scores cannot be manipulated.

   - Organizational Capability and Structure
   - Scope of Services
   - Staffing Requirements
   - Reporting and Technology Requirements
   - Subcontractor Requirements

   The Business Proposal will only be evaluated for Respondents who have achieved a minimum of 75% of the available points in all previous criteria.

   - Business Cost Proposal

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 the right to negotiate a contract with the Department. Such negotiations may, but will not automatically, result in a contract. Pursuant to Governor M. Jodi Rell's Executive Order No. 3, any resulting contract will be posted on the State Contracting Portal. All unsuccessful Respondents will be notified by e-mail or U.S. mail, at the Department's discretion, about the outcome of the evaluation and Respondent selection process.

i.[i] Source: interChange Reports TPL-0908-M, Cost-Avoided Claims Listing Medicare, TPL-0909-M, Cost-Avoided Claims Listing Other Insurance; HMS - Recovery Report Summarized And By Project - June 2011; Center for Medicare Advocacy monthly reporting for skilled nursing facility, chronic disease hospital and home health recoveries

ii.[ii] Public Act 11-61, Sec. 124, General State Statute Section 17b-261m authorizes the Department to use an ASO model; An act implementing the revenue items in the budget and making budget adjustments, deficiency appropriations, certain revisions to bills of the current session and miscellaneous changes to the general statutes.

iii..[iii] Pursuant to Title 42, Code of Federal Regulations, Part 433 Subpart D - Third Party Liability and Connecticut General State Statute Section 17b-265 (Formerly Sec. 17-134f). Department subrogated to right of recovery of applicant or recipient. Utilization of personal health insurance. Insurance coverage of medical assistance recipients. Limitations

i[i]v. The State of Connecticut Department of Income Maintenance et. al. v. Donna Shalala, Secretary, Health and Human Services (United States District Court for the State of Connecticut, 2 :91-CV00546 (AHN); established the subrogation right of the Commissioner of the Connecticut Department of Social Services (previously known as the Department of Income Maintenance) to seek initial determinations and appeals of Medicare coverage for dual eligible clients.

v.Home health agencies issue HHABN's to Medicare beneficiaries for reasons related to the absence or cessation of Medicare coverage when a beneficiary has liability protection under § 1879 of the Social Security Act and in conjunction with home health agency responsibilities under their Medicare conditions of Participation.

vi. Connecticut Department of Social Services Medical Assistance Program Provider Bulletin 2010-06, January 2010; Medicare cost avoidance requirements initially scheduled to go into effect February 17, 2010. Due to home health industry-wide claim submission software not supporting these requirements, and the modification time needed to do so, the Department held off on Medicare cost avoidance until April 1, 2010. Effective April 1, 2010 when submitting Medicaid claims for services delivered to dual eligible clients', Home Health Agencies are required to indicate the reason it determined a client's care did not meet Medicare coverage criteria, which resulted in the issuing of a HHABN to the client. Medicaid claims will cost avoid (deny) in situations where the provider does not indicate the reason for, and the date it issued a HHABN, which determined the client's care did not meet specific Medicare coverage criteria.

PART FIVE PROPOSAL OUTLINE

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

Page

Binder One (1)

Binder Two (2)