State of Connecticut Department of Social Services Procurement Notice
Person-Centered Medical Home Plus Program, Wave 2,
Request for Proposals (PCMH+W2 RFP)

The State of Connecticut Department of Social Services is issuing **Addendum 3** to the Person-Centered Medical Home Plus Program, Wave 2, Request for Proposals (PCMH+W2 RFP)

All requirements of the original RFP except those requirements specifically changed by this addendum shall remain in effect. In the event of any inconsistency between information provided in the RFP and information in this addendum, the information in this addendum shall prevail.

A. References

Please be advised of the following edits to e. References in both TRACK 1 and TRACK 2:

e. References

Provide three (3) specific programmatic references for the Respondent.

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

ensure the accuracy of their contact information, and their willingness and ability to provide references. The Department expects to contact these references as part of the evaluation process.

References shall be able to comment on the following categories:

- Capability to implement PCMH+;
- Organizational approach; and
- Ability to problem-solve.

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

B. Additional information to Addendum 2, B. QUESTIONS AND RESPONSES
#29. Question: Data and Outcome Monitoring:

29.a. How will data and outcomes be monitored?

Response: The providers can send CCDs, QRDAs, or other structured documents and the technology solution will calculate the core eCQMs that have been identified by the PCMH+ group. This is intended to be a short-term effort pending the identification and deployment of a statewide solution.

29.b. Is there any additional data collection/requirements or specific batching requirements required for this project?

Response: If the PE wants to batch CCDs, QRDAs, and other standard documents we would work with them to set-up a cadence, test the connections. We intend for this to be an automated process thereafter. We will monitor the feeds. If something does not work, system alerts will notify us of a problem. Additional data would be required by the program if new measures are identified for participation in the PCMH + initiative and the agency does not collect those data today. This would be a program requirement not a technology requirement.

29.c. What are the system requirements to transmit admission, discharge, transfer, and care summaries?

Response: This depends on the system. Hospital systems typically create ADT messages for management of patients within their system. If outpatient facilities generate ADTs, then our system can consume those messages. Mostly, in this space we would like to work with the agency to understand what they can create natively for any and all interactions with our beneficiaries and we would receive and aggregate that data.

29.d. How are care summaries transmitted?

Response: Care summaries would be transmitted using standard protocols, CCDs, CCDA, HL7, etc. We can also send pdf's but that is not considered structured data. Our goal is to work with the provider, identify their preference and work within their workflow for optimal results.

29.e. Will all data and outcome results be retrieved from CHN/Claims Data/CareAnalyzer/Hedis measures or will we have to put data into a separate database?

Response: Data will be put into platforms that can 1.) consume standard data types and 2.) are certified to produce a valid eCQM and/or HEDIS computation as desired by DSS. CHNCT would not be the target for this data collection and/or aggregation. The department has multiple options for the consumption and processing of these data.

Continued on next page…

C. Transcription from meeting held, January 17, 2018 for Participating Entities from PCMH+ Wave 1.

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

January 17, 2018

DSS Central Office
55 Farmington Avenue
Hartford, Connecticut

WAVE 2 PROCUREMENT

PCHM+ COLLABORATIVE MEETING

(Transcription from Electronic Recording)

Transcription Services of
FALZARANO COURT REPORTERS, LLC
4 Somerset Lane
Simsbury, CT 06070
860.651.0258
www.falzaranocourtreporters.com

SPEAKERS IN ATTANDANCE (present in person and telephonically:

NAME	ORGANIZATION
JOEL NORWOOD	DSS
MARCIA McDONOUGH	DSS
NICOLE GODBURN	DSS
ROB ZAVOSKI	DSS
KATE McEVOY	DSS
FAINA DOOKH	SIM - CT State Innovation Model
CHARLES LASSITER	Mercer Consulting
CINDY WARD	Mercer Consulting
BRAD HORMAN	Mercer Consulting
LOU BRADY	Cornell Scott-Hill Health Center
SASHA HANDLER	Cornell Scott-Hill Health Center
ROSE SWIFT	Cornell Scott-Hill Health Center
KIRSTEN ANDERSON	Value Care Alliance
MICHAEL HUNT	St. Vincent’s Health Partners
KATHY YACAVONE	Southwest Community Health Center

CATE DANGREMOND Northeast Medical Group, Yale-NH

CRYSTAL SCHINDO Northeast Medical Group, Yale-NH

MELISSA BONSALL Generations Healthcare

SUE LAGARDE Haven Healthcare of CT

DOUG OLSEN Fairhaven Community Healthcare

JEANNE O'BRIEN VCA

(Proceedings commenced at 10:01 a.m.)

JOEL NORWOOD: All right. So, it's now 10:01 on Wednesday, January 17, 2018. This is the Wave 2 Procurement portion of the PCMH+ Collaborative Meeting held in person here at DSS Central Office, 55 Farmington Avenue, Hartford, Connecticut. And in large part due to the inclement weather a number of participants are also available, are participating by telephone.

We particularly ask now that we're on the record if everyone who speaks, before you speak if you can identify both your first and last name and what

organization you're affiliated with, and please try to speak as slowly and clearly and loudly as possible so that everyone can hear both on the phone and so that the recording is as accurate as possible.

So it's perfectly fine to ask questions that overlap between Wave 1 and Wave 2. That's fine. We just want to make sure that there's a full recording so that all the information being provided about the current process is available and made part of the official record.

Okay. So now there's no -- any questions about Wave 2 or overlap between Wave 1 and Wave 2, feel free to ask whatever questions you'd like.

LOU BRADY: Lou Brady, Chief of Operations at the Cornell Scott-Hill Health Center.

My question relates to our ability to engage patients who may have opted out in Wave 1 to be able to engage them for participation in Wave 2. We recognize that there had been certain commitments to

confidentiality around opt-outs, however we would like the ability to share information to successes of Wave 1 and 2, the benefits of participating in Wave 2. Could you provide us guidance as to the limits of our ability to do so?

KATE McEVOY: So, I will start (unintelligible) DSS and then quickly Segway to my colleagues. First of all, I want to reflect back we share your interest in engaging people and certainly we want to afford people of the right and opportunity to choose whether or not to participate based on our method of attributing using our identified attribution method and then assigning them but preserving the ability to opt out at any point on rolling basis. So just to reinforce our kind of procedural standards there.

Our intent as we've shared with you is to refresh that attribution process, so I'd like to defer to my colleagues to talk about the timing there, and also we will anticipate that there will be formal notice to

individuals identified as attributed to each of the participating entities, but just for the entities that will be carrying forward in the wave to you and then any new participating entities that are essentially contracted through the procurement process.

And that notice, we welcome your feedback on that timing, and then also the content of that notice we painstakingly crafted notice for the first wave, but as you said I think there was definitely some challenges of interpretation and familiarity with the project, and now we have more maturity and it's track record to point to you in terms of the participation.

That said, we had a very small number of formal opt-outs comparatively. I will say forthrightly our greater challenged was individuals who attritted from the program on the basis of eligibility. And so I think that's something welcome for the comment and question on, but we can talk about first of all that refresh of attribution and then some of the strategies

around need and some participation on the basis of eligibility.

So, may I ask whomever would feel most situated to answer that question on the timing of attribution?

NICOLE GODBURN: Nicole Godburn, DSS.

So, the timing of the attribution, we will take your March lists, run it through the same process that we did in Wave 1, the exclusions, et cetera, blah, blah, blah, and then issue that to you for the start of April 1.

UNIDENTIFIED SPEAKER: So that will be based on March data?

MS. GODBURN: Yes, correct.

UNIDENTIFIED SPEAKER: On April? Would you get it on April 1?

MS. GODBURN: Let me double check on the timing of when it will be issued to you, but I'm trying to recall what we did for Wave 1. I think we gave it to you a little bit before.

UNIDENTIFIED SPEAKER: It was before.

MS. GODBURN: Yeah.

UNIDENTIFIED SPEAKER: It was October and the program started January.

MS. GODBURN: Right. So I think it as November-December-ish, somewhere around there that we gave it to you too. We'll get it you before -- but it will be your March list. It will be that run.

And as far as the opt-outs, I think we'll have to have a little bit of a conversation about that, about how to reengage those members, you know, obviously citing member rights and their ability to move practices, opt out of programs, et cetera. I think we'll probably have to talk a little bit further about what's the best approach for that.

MR. NORWOOD: Okay.

ROB ZAVOSKI: One comment. Rob Zavoski with the Department of Social Services.

I think there's two different ways that folks may

have opted out. One is if they've chosen to go elsewhere, and the other is if they opted out but they're still being seen at your center, and I think we would need to look at those two differently. And I'll leave it at that but we'll have to look at that.

MR. NORWOOD: Thank you.

KATE McEVOY: Kate McEvoy, DSS.

So really, you know, I think that embedded in that is that it has their selection of another usual and customary place of care affected their attribution status and it's essentially a feature -- it may essentially be attributed to another entity on that basis. But if it is an opt-out I think there is room for us to consider, you know, refreshing the notice and giving people an opportunity to reconsider. So, we will discuss that, and we'll definitely broadcast the Department's position on that.

MR. BRADY: Lou Brady, Cornell Scott-Hill Health Center.

I wonder if it's possible in the notice to offer the local participating entity as a resource for further explanation and guidance on the benefits of the program that may give them a local contact that they are familiar with that they could feel the ability to have a question and answer in real time.

Ms. McEvoy: I appreciate this feedback (unintelligible), I appreciate that suggestion. Let us take that under advisement and we can definitely broadcast our position.

I think the -- just to be clear about our original intent was we had contracted with a third-party enrollment facilitator essentially. It wasn't a broker for participation as we might have done under our earlier managed care arrangements, but essentially it was neutral third party that would manage opt-outs. We anticipate continuing that relationship because we felt it was important that there be a disinterested party involved in that effort so that there would be no sort

of weighing of pro or con. But I appreciate the suggestion around the -- we appreciate the suggestion around local contact and we'll definitely consider that.

KIRSTEN ANDERSON: So this is Kirsten Anderson from Value Care Alliance, and we actually have a series of questions around the suggestion about an (unintelligible) server, and apparently there is some history within the state, and Michael knows more than I do about that, but we really need an explanation of this and whether that is a requirement.

As unproven technology we're very hesitant around that, so we just didn't understand the wording of Wave 2 as to whether that is required, whether that isn't. So if you could expound on that that would be great.

MS. McEVOY: This is Kate McEvoy from DSS. I appreciate that question. We are seeking technical clarification internally and if there are any other questions related to the health information technology

requirements I would actually appreciate participating in any of these, record those in writing. That would enable us to get that (unintelligible) and broadcast it. So, we'll definitely consider that question already asked, but the other related questions, please let us know and we will get them all broadcasted in (unintelligible).

MR. NORWOOD: Right. And this Joel Norwood, DSS. The sooner the better because we want to make sure that we can give all of you and all potential RFP respondents as accurate information as possible. And of course, as with any question about the RFP that needs to go through our official contact, Marcia McDonough, sitting right next to me, but --

MICHAEL HUNT: This is Michael Hunt from St. Vincent Health Partners.

The RFP says it's a recommendation. And then there's another section in the RFP that says it's a requirement. So I mean just in that alone, A, it is a

challenge. But B, I think we need to understand what technical requirements is being recommended because there are inherent costs that may be beyond our ability to adjust into our budgets since our budgets are not state cycled. So we're anticipating that's a big -- just the technical requirements is a big huge concern of our members.

MS. McEVOY: Kate McEvoy, DSS. Well-stated, and we really sincerely invite any clarifying questions on that that you may have and we'll consider that to be part of the formal request already. Thank you.

MR. NORWOOD: Right. But again, if you can also put it in writing that would be very helpful to us. So that as we take the questions to various technical experts that there is as much detail as possible to simply -- we're not technical experts in any of this, so if you can take whatever specifics including from your technical staff so that the right details are being translated to people who understand them.

MS. ANDERSON: So, this is Kirsten Anderson from Value Care Alliance again.

Do you have a timeframe on that? So if we do send in -- we will send in questions around this because it's very, very important to us, what is the timeframe for getting a response so that we understand our timing for participation in Wave 2?

MARCIA McDONOUGH: Right. I'll do my best to get the response out to you. I would say --

MR. NORWOOD: Or out to everyone rather.

MS. McDONOUGH: Exactly. To everyone, because it's posted as an addendum to the public. As soon as possible, I would say no more than one week, okay? I hope that gives you guys enough time to get the -- you know, to read the response and then decide if you'd like to participate. And it could be sooner than that. I'll do my best to get it out as soon as possible.

MS. McEVOY: And I hope I'm not speaking out of turn, Marcia -- this is Kate McEvoy, DSS again -- to

say that we have Bidders Conference tomorrow --

MS. McDONOUGH: Yes, we do.

MS. McEVOY: -- so I keep thinking is -- Thursday is further away than tomorrow, but tomorrow is the day. We have a Bidders Conference so interested parties for Wave 2 that are not at the time participating in it is -- will be coming, will be afforded an opportunity to pose their questions, so we will have an opportunity to kind of pull all that together this week in furtherance of Marcia's response.

MS. McDONOUGH: I'm scheduled to release all responses January 29th, but if I can get your answers to your questions I'll do that sooner than the 29th as an addendum to this meeting.

SASHA HANDLER: Hi, this is Sasha Handler from Cornell Scott-Hill Health Center.

For Wave 2, will the timeline and expectations around site reviews, the assessments follow the same or a similar trajectory as it did for Wave 1?

MS. GODBURN: This is Nicole Godburn, DSS.

Let me touch base with the Mercer team because we're now going to be entering into a two-year wait to -- and because we're starting in April, not necessarily in January, we may shift a little bit. So we'll have to touch base with the Mercer team to figure out timelines, and I look to Charles assuming that would be correct for Cindy's team.

CHARLES LASSITER: Yeah, I think we (unintelligible) to make sure the money is up from a long-term standpoint.

MS. GODBURN: Yeah.

CHARLES LASSITER: (Unintelligible.)

MS. GODBURN: Yeah, but again, you know, wanting to give you as much notice as possible like we did during Wave 1 so you have time to prepare, get ready and then all that so we give you as much notice as possible. But we may probably shift a little bit just due to starting in April.

MS. HANDLER: Thank you.

MS. ANDERSON: This is Kirsten Anderson from Value Care Alliance. But it's still anticipated you'd want a year audit?

MR. LASSITER: I would be for the program year, which the contract year is starting three months in, but the program year is going to be calendar year. So, in effect there's going to be no bridge between activities expected, though compliance during the three-month period may change because of the gap in the budget period that resulted from the passing on time, which we can talk about a little bit more.

We also have Cindy Ward, our clinical lead on the line if she wants to talk a little bit more about how we think the reviews might be structured.

CINDY WARD: Hi, all. This is Cindy Ward with Mercer.

Kirsten, thank you for the question. We are still working with DSS on what that would look like for Wave

2 in the program year two, and how these would structure that particularly for what we would probably be referring to as legacy providers, those nine providers who were in Wave 1. So as soon as we have that information available we would be sharing that with all of the participating providers for Wave 2.

MS. ANDERSON: Thank you.

KATHY YACAVONE: Hi, Kate. This is Kathy Yacavone, CEO at Southwest Community Health Center.

Just a question, on the December call DSS stated that the $4.50 PMPM would still be carried over through into Wave 2, and I was just wondering giving -- I know the federal and state budget issues, is that still locked in?

MS. GODBURN: This is Nicole Godburn, DSS. Yes is the short answer. So PMPM for Wave 2 will be $4.50.

MS. YACAVONE: Thank you.

MR. HUNT: This Michael Hunt, St Vincent Health Partners. Obviously, the alternative for the advanced

networks, what does it look for the grants for that, that block of funds that might be available?

MS. McEVOY: Kate McEvoy, DSS. So just building on the last answer, we have commitments and state funds that are eligible for a federal match. Some of that is matched at the higher level for our expansion population, some is matched at the traditional level. But there is -- just to build on the answer to your question, Kathy, there's no change in the budget commitments around that supplemental payment at 4.50 to both the legacy participating entities, so I think we're going to start using that term as others have mentioned. And then also any new FQHCs that compete successfully in the procurement process, very unfortunately we were not able to extend that pool of dollars to the advanced networks. I want to say we recognize that you do have very defensible up-front costs and ongoing costs to support the care management function, so I am sorry that we don't have the budget

wherewithal to do that.

We have confirmed and I want to certainly defer to our colleagues in the SIM PMO that the SIM PMO does again anticipate making grants of SIM funds to the participating advanced networks, both the legacy advanced networks, and then any new advanced networks that are procured through the Wave 2 RFP.

Jenna, Faina, would you like to comment further on that?

FAINA DOOKH: Thanks, Kate. This is Faina from the SIM office.

We are making funds available and that solicitation for the CCIP transformation awards will be released after the solicitation for the PCMH+ program ends so that you don't have to work on two RFPs at once. So legacy participating entities do not have to submit another RFP that will the second between the SIM office and the legacy PEs in extending or offering any supplemental awards that go along with CCIP.

We are also offering additional funding with a new prevention service initiative program of direct funding that will be available in the late spring of 2018 as well.

UNIDENTIFIED SPEAKER: This is Sue (unintelligible). If I could segway on that question. So I think the last time we spoke, despite the acknowledgement of the issues with attribution and the fall-off, that DSS acknowledges that's a significant issue. What I took away was that it was just going to be a very difficult problem to solve. So I'm just wondering if that still is the current status.

MS. McEVOY: Well, let me actually ask Nicole -- this is Kate McEvoy, DSS -- ask Nicole to detail the strategies that we're going to use to support continuity for Wave 2.

MS. GODBURN: Nicole Godburn, DSS.

So, Sue, to answer your question, it was outlined in the RFP and also check out the state plan amendment

which is posted on the DSS website because that outlines it as well. But for the -- the problem that we had with eligibility in Wave 1 was that if somebody had a gap in eligibility they fell off of your roster in Wave 1 and therefore you didn't see them pop back on throughout the performance year.

So what we did was we looked up population on Wave 1, kind of identified how the movements flowed with members who lost eligibility and going into Wave 2 what we'll do is -- let me just find the wording, sorry, to say this correctly. So care coordination add-on payments being made to FQHCs for individuals assigned to you or otherwise eligible for PCMH+ lose eligibility for Medicaid but are reinstated retroactively no later than 120 days will come back on.

UNIDENTIFIED SPEAKER: Oh, okay.

MS. GODBURN: Yes. So if they --

UNIDENTIFIED SPEAKER: That should make a huge difference.

MS. GODBURN: Yes. So if they get their Medicaid eligibility reinstated within that 120-day period you'll see them come back on your roster.

UNIDENTIFIED SPEAKER: Great.

MR. NORWOOD: But so that they're -- but only if they're retroactively restored to the day they became ineligible.

MS. GODBURN: Yes.

MR. NORWOOD: So that retroactively they had continuous eligibility.

UNIDENTIFIED SPEAKER: Okay.

MR. NORWOOD: But not if someone actually fell off.

MS. GODBURN: Fell off, was not reinstated but maybe came back on later on for another purpose, reason, then that would not apply.

MR. HUNT: This is Michael Hunt, St. Vincent Health Partners.

So using the portal to data is really on our part

excruciatingly painful and for the diversity of our members and the attribution is problematic. Can we figure out a more effective way to share data on the claim size so that we can use our information platforms more successfully?

MS. McEVOY: Kate McEvoy, DSS.

Could you elaborate on that when you talk about the difficulty in access? So just to reinforce previous messages, we've given you essentially prepared reports and we have detailed those random domains that are covered. And then we also give the admission/discharge transfer data as well as some clinical data.

Can you let us know more specifically what are the transactional difficulties and what could we do differently that would help us locate that because that's very useful for us?

MR. HUNT: I'll let Kirsten start and then that way I won't duplicate --

MS. ANDERSON: Right. So this is Kirsten Anderson from the Value Care Alliance.

So, for us we aggregate data from all of the sources that we have including other pairs, and we run queries on that data to be able to highlight high risk patients to and to highlight opportunities. And the fact that the data is given to us in sort of a flat format already predigested makes it so that we are unable to run our queries to identify the patients.

And so having claims data directly from CHN would be extraordinarily help for us to be able to run queries to put that information into a user interface that is friendly for our providers such as a (unintelligible) or something like that.

I want to make the comment that, you know, we do crunch through the data that we have. We have to merge all kinds of data, sew it together, send it out to our providers, and that does take an excruciatingly long time and that's why we are asking for a claims data and

actually have been working with the SIM PMO to describe how that data could come to us in a de-identified way. So what would it look like; how would those fields that are of concern be masked? What would happen with, you know, certain summary data?

And so working with the SIM PMO would provide examples of how that could happen so that we could start to work on getting this data more effectively.

MS. McEVOY: So -- Kate McEvoy, Department of Social Services.

I think we really -- we're looking to engage on this. We want to accept the greatest utility; the more specifics you can give us the better. So I really appreciate your reference to kind of detailing exactly what that would be from a transmission standpoint, how would we protect for the requirements of law around confidentiality as to certain information, and we're looking to (unintelligible) this, but it's hard for us to have a consensual perspective about it. So I think

as much as we can translate this into very specific requests that help us we can (unintelligible).

CATE DANGREMOND: Kate, this is Cate Dangremond, I'm from Northeast Medical Group, Yale-New Haven Health, and I would just like to echo what Kirsten brought up and what Michael bright up relative to access to data. And we've, you know, faced the identical challenges in terms of being able to be more efficient with the time and resources we have if we have the raw data rather than kind of the re-developed reports that are available.

We also have been working with the SIM PMO similarly in terms of trying to provide inciteful answers to questions they've had about what that could look like. I think, you know, something that we've certainly faced too that makes some of the existing reporting structure challenging that we've also talked about is, you know, there are more people accounted for in some the portal tools that are available than those

that are attributable through PCMH+, though the amount of time we ended up spending just trying to crunch data that we could really be putting that time toward actively working with members, and if we were able to use some of our existing workflow tools I think would be a substantial win all around and would let us spend time on more meaningful work for the program.

MS. McEVOY: Kate McEvoy, DSS.

Kate, we thank you very much for building on the previous comment. And again, just to say you all have such familiarity with the need for interface with your systems that we would be very educated by hearing more specifics around that. I think this has definitely emerged over time and we don't want to seem unresponsive, but we do need more detail on what we could do to facilitate that.

So please do communicate with us at the earliest possible juncture point. You know, we're in a procurement period so it would give us the best

opportunity to anticipate that.

And also as Joel had remarked earlier that, you know, engage with technical colleagues here because this is not our bailiwick in the Department.

So would anyone else like to add anything?

MS. GODBURN: Nicole Godburn, DSS.

Echoing what Kate said, if I can include, since you mentioned working with the SIM PMO, if I can just ask of Faina if you could just kind of keeping us in the loop a little bit on those conversations so we can just make sure that we're all kind of making the same connections and trying to work towards the same end result.

MS. DOOKH: Hi, this Faina from the SIM Office. Absolutely, we have been synthesizing a lot of our conversations with the PEs in trying to give accurate guidance to DSS. So we can go through and see what we have set so far and maybe create a compilation of some of the feedback when we get the data. This would make

it easier on your end.

MS. GODBURN: Sure. Yeah, that would be a good starting point. Thank you.

MELISSA BONSALL: This is Melissa Bonsall from Generations. I have a follow-up question on eligibility.

MS. GODBURN: Sure, go ahead.

MS. BONSALL: Okay. We were discussing if a case member is found to be retroactively eligible for Medicaid that they would be put back on for the list in terms of enhanced services. And so my question would be are we also then going to expect retro payment reconciliation if they had been meant to have been, you know, retroactively eligible three months ago, would that then affect the financial statement?

MS. GODBURN: Nicole Godburn, DSS.

A short answer is yes. So if that member fell off, came back on within the 120-day period, you wouldn't see PMPM payment during that 120 days

obviously because we can't predict if they're going to come back on. But if they do come back on then you're going to see a retro payment to cover the time that they were off.

MS. BONSALL: Right. Thank you.

SUE LAGARDE: Sue Lagarde for Haven.

If I can sort of take Kirsten's argument and go a little more downstream, and it has to do basically with the metrics that we're using. So, one of things that I think would be extremely -- so given that metrics are just not simple reflections of what's happening on the ground, there's a big IT system in the middle between what's actually happening and what gets reported, which unfortunately is issues in a negative respect.

It would be extremely helpful and since we're working, we're all working with our individual IT systems to enhance that, but sometimes we don't really know if it's really working as well as we want to, getting sort of rolling 12-month HEDIS measures would

be incredibly useful. I know that Dr. McGraw (phonetic) at CHN says that that's something that is certainly -- he would love to see. I don't want to quote him but that's what he said to me as well.

But I'll give you an example and I know Dr. Zavoski, because we've had conversations about this, the developmental screen for kids under the age of 3. So that is a complicated -- it may not seem complicated, but it can be a complicated measure to report because DSS asks that we all report a positive or negative, although FQHCs are exempt from that, but it -- that becomes then complicated in what gets reported.

To give you another example the way the metric reads it was very difficult for me. I had conversations with Nicole and Dr. Zavoski about how is this actually getting measured. Because, for instance, at Fairhaven we use the M-CHAT, and the American Academy of Pediatrics recommends that this be

administered at age 18 months and 24 months, whereas the metric measures ages 1, 2 and 3.

So although we believe that on a clinical basis we're delivering quality, on a measurement basis our numbers are not as good, although they've improved because we've managed to improve the IT piece.

All of that is a segway to say I really couldn't assess what was going on until I sort of know how your -- I know what we're doing. So I'll give you an example. So Dr. McGraw very graciously gave me the last 12 months for that metric for Fairhaven just literally yesterday, recognizing there's still a run-out and so it's still not a perfect number. And it showed that it's getting picked up, which is great news, but the number is probably about a half of what we would have said patients are meeting that criteria based on our 18 and 24-month criteria, as opposed to the measure of ages 1, 2 and 3.

Long story, but I guess I -- my concern is I

really want to get recognizing claims data before -- the limitations of claims data broadly. Even within that I'd like to get those as close to reflecting true quality rather than just being some number where we're, you know -- and to do that to wait a whole year and a half to know what you're doing, how it translates to that is very difficult. Anyway, long story.

ROB ZAVOSKI: Rob Zavoski, DSS.

I would have to have to speak with Dr. McGraw to see what it is that he's promising.

MS. LAGARDE: He's not promising anything. He's just saying that was something he would love to see too.

DR. ZAVOSKI: Yes, which I think is his way of saying he can't do it.

(Laughter.)

DR. ZAVOSKI: I need to follow up with him on that. And I recognize the challenges of HEDIS measures because they are compromises across a wealth of payers

nationwide and so they are imperfect in all settings. If there's another measure that would fit the bill better then we can (unintelligible). So, yes, I wish.

MS. LAGARDE: Does DSS have any input into -- I mean I guess the question is twofold. Can CHN -- is it technically possible to do a rolling 12-month HEDIS, and then -- that's number one. And number two, can DSS approve them to do that?

DR. ZAVOSKI: If it's possible we can approve it? I'm not sure that it's possible, I'll have to look at it. Dr. McGraw's answer again suggests to me that he would like it to (unintelligible).

MS. LAGARDE: Okay.

MS. McEVOY: Kate McEvoy, DSS. I do want to say, you know, I'm not a (unintelligible) and I don't have the expertise in the mechanics of the measures, but I think we acknowledge we -- for instance, for the developmental screens, that was an example of DSS interest in not being too descriptive. We wanted to

save you -- you have the clinical expertise to choose the tool that best aligns with your clinical practice and your understanding of evidence. And that said, that the measures, we really have to have fidelity to the definition of the measures which is like saying something extremely elementary to someone with your knowledge base, but I think there is a challenge in aligning that flexibility around the practice and then how we capture the data across all of the participating entities.

So I think the conclusion that I have to draw from the discussion is, you know, let's examine the measures, (unintelligible) appropriately, you know, focused that I don't otherwise see a way of reconciling your comments around the different points in time in terms of the child's age with the measures.

DR. ZAVOSKI: Rob Zavoski, DSS.

I think our fulcrum measure that includes kids from 1 to 18 might actually be a better way of doing

it. I have to look at that with the IT people who look at it differently with their (unintelligible) jaundiced eyes to say whether we (unintelligible.) So we will definitely contact them for the next (unintelligible).

MS. LAGARDE: Thank you.

MS. McEVOY: Again, Kate McEvoy, DSS.

You know, if there are questions of interpretation that essentially you can detail with your opinions and observations as part of the procurement process because the quality measures that is captured in the submission of Wave 2 that details the Department's present intention around it, but if there are observations you can make through questions of interpretation it would be very helpful to us. So that's one that we're obviously --

UNIDENTIFIED SPEAKER: We've -- Dr. Zavoski and I have discussed this venture before.

MS. McEVOY: Yeah, but there may be, you know, there may be a more general benefit. So just saying,

you know, again as much as we can memorialize that and as we're doing right now, then broadcasting the response to every interested party, I think it's certainly an issue of broader concern.

DR. ZAVOSKI: Rob Zavoski with DSS.

The challenge you raise is the challenge of using claims data. You know, it's a very inexact science which then I hear from other participating entities that they really want our claims data even though I would think that their own IT systems will be able to generate a more proximate pattern that would be much more valuable. So I find it an interesting dichotomy.

DOUG OLSEN: Doug Olsen with Fairhaven.

Kate, you had alluded to before that there are certainly a lot of innovative programs going on in the state, certainly CCIP, CMMI, funded opportunities, other PTN network-type opportunities, and then of course PCMH+. I was wondering if somebody could just deliberately address some of the work that's likely

been done behind the scenes regarding a crosswalk or harmonization among measures across these different programs. Certainly for those entities participating in three or four of these, it's three or four times the reporting measure, and any way to harmonize them I think would be greatly appreciated.

MS. McEVOY: Kate McEvoy, DSS.

I totally appreciate that question. We had been very deliberate at the outset at first -- first to go kind of go back in time we had reached a point of, you know, very great maturity in the model design development of PCMH+ when we became aware the CHE acts, proceed on the PTM grant which was terrific. We all did have to say at that point what is the scope, what's the emphasis points for use of the federal funds to make assurances to the federal government that we're safeguarding its duplication, but also aligning these things.

At the time we created, we kind of used best

efforts to create a grid that has embedded within it links to all of the kind of central features of not only those projects that you identified that also are persons in a medical home and the advanced medical home effort in SIM. So what I would like to offer is that we would circulate again a link to that grid because I think it is -- as best as possible captures the intersection of the requirements, notwithstanding your comments certainly well taken in terms of the ongoing obligation of the involved entities, DSS, SIM PMOs, CHC (phonetic) to examine reduction of burden for the involved entities.

So, I think that usefully calls -- refreshes our attention on that. But I do want to make sure that everyone has on hand that grid because it does do our best to kind of capture the parameters of each of those and how they're related and how they're distinguishable.

MR. OLSEN: Thanks. And I have a follow-up

question that is not at all related regarding -- I think this may apply only to FQHCs from Wave 1 into Wave 2. Certainly for Wave 1 some of the people that we had to hire to operationalize PCMH+ Wave 1 were somewhat prescriptive in terms of really people with behavioral health experience or with a particular focus. Do you envision those same prescriptions being in existence for Wave 2 or would there be more flexibility in that regard?

MS. GODBURN: Nicole Godburn, DSS.

I'll work with Marcia to issue this formally, but off the top of my head we did not change any of that. Those were not any of the changes when we went into Wave 2. But we'll double check that and issue that through Marcia.

MR. LASSITER: Yeah, and I think -- this is Charles Lassiter from Mercer. I think some of that has played out in the compliance reviews and I see how that's been applied in practice, who's been hired to

(unintelligible), they've been used in things like that. So as we could only tip the technical assistance portion in the first half of this next year, I think there will be a time to evaluate whether those prescripted natures of required hirings is truly, you know, bearing out it's intended purpose or whether it's just becoming a body that's ended up doing things outside the scope of what we intended, working more on care management than behavior health directed treatment or interventions. Things like that.

I think right now it's a little bit too early. We see in the rolling reports monthly but as that compliance review wrapped up and we continue talking to the participating entities in a more involved fashion with the legacy folks then we will the new wave. I think we'll have a better idea of whether that is achieving its intended purpose or not.

CRYSTAL SCHINDO: Hi, this is Crystal Schindo from Northeast Medical Group.

Can you please repeat that? I think it was Charles that was speaking. It's very hard to hear. Thank you.

MR. LASSITER: Yeah, I was just suggesting that the question that came across was in the second year of Wave 1 are we willing to change the standards for which the PEs need to hire staff. And Nichole Godburn answered no, in the second year contract that doesn't change, and then I suggested that we have more data points now via the compliance reviews with the participating entities, is whether that hiring in that specificity within the requirements is bearing out its real purpose of if we're seeing bodies hired to do things that aren't necessarily what they were intended to do. For example, a behavioral health specialist doing more care coordination or peer counseling-type activities where a community health worker would have done appropriately in that context.

I think those types of things will bear out as we

review the compliance reviews and continue talking to the Wave 1 participating entities. As mentioned earlier, the legacy entities ought to have -- they're continuing to use those individuals. So we should have a better idea going forward, but for right now I don't think those contract requirements have changed.

MS. McEVOY: This is Kate McEvoy at DSS. I also really appreciate this question because this kinds of goes to what we referenced earlier around kind of the evolution of this program ongoing.

So a couple things. The premise of that sort of requirement I think we actively -- we actively debated the level of prescription because as shared our overall intent is to give as much flexibility of our local businesses as possible. That said, Mercer was very instrumental in review of what care coordination elements were embedded in the NCQA and JACO (phonetic), PCMH guidelines. Also the statutory obligations for the Federally Qualified Health Centers.

We kind of made a very critical examination of, you know, because we're very consciously developing our PCMH with kind of amplifying those care coordination features. We also looked at our data well-known to you, Dr. Olsen, incidents of individuals with behavioral health conditions and SED and medicated. It's on that basis that we said we erred on the side of greater prescriptiveness.

What we'd like to say is that is embedded in the Wave 2 but ongoing with the provider collaborative we'd really like to hear you surface like how does it actually manifest on a practice basis because all of you have embodied that commitment to the integration of behavioral healthcare and it's translating in different ways across the state. So let's continue to surface that consistent with the discussion of evolution of a measure set. We really want to look at that, and also examine is that creating barriers from the standpoint of your model and/or availability of staff, because we

know that's an increasing challenged in terms of the particular credentials.

So we're keenly interested, but that was kind of the genealogy of that set of decisions that we made which we feel still holds true in terms of unmet needs and the barriers for people historically. And I know that in your leadership role you champion this all the time, so we really, really rely on your expertise to help us understand and evolve with that.

DR. ZAVOSKI: Rob Zavoski, DSS.

I remind Kate periodically of the (unintelligible) innovation. We're really interested to see which innovations work systemically, which innovations are working in some places but not so well in other places, and to learn from that. And I think we have a wonderful opportunity to do that, make challenges if we're all impassioned and want it to work right now, and it takes a little time.

MS. DANGREMOND: This is Cate Dangremond, I'm from

Northeast Medical Group Yale-New Haven Health.

One incredibly important question for us as we contemplate year two that I did read but I think some guidance on this in the RFP but would like to clarify if we could. We have several practices that have completed PCMH recognitions since Wave 1, some of whom were listed on our Wave 1 application but were kind of in that 18-month period, but we knew that their work was already in progress. We also have some who are now PCMH recognized but were not on that initial list at all.

I do see a note on page 30 saying that that's not (unintelligible) composition by providing appropriate documentation to DSS. But are you able to just clarify that I'm reading that properly and that we as advanced networks will be able to add additional practices that have received recognition since Wave 1 into our network?

MR. HUNT: And can I -- this is Michael Hunt. Can

I also add to that? I think from our networks as there is growth in the marketplace, can we do that on a rolling basis so that we're not having to wait a (unintelligible) amount of time to get a new provider site identified? I mean I know it makes the calculations more challenging, but from an access perspective we're taking care of those patients anyway. So, you know, if you view it as a payor, I mean payors are allowing us continuously for our contracts to adjust our provider base.

MS. GODBURN: Nicole Godburn with DSS.

So I'll take the first part of that of yes, advanced networks can adjust the structures of their network going into Wave 2. So as outlined similar to what you did in Wave 1 when you gave us like your full list of your practices, et cetera, identifying those that will be part of the network, we'll need that so that we can run your attribution list to get you your proper list of members. And of course that would all

be through Marcia sending all of that information since that will be part of her process as you transition from Wave 1 into Wave 2.

As far as doing it on a rolling basis, I kind of look to Charles because as you mentioned the challenge would be calculation and how we would do that.

MR. LASSITER: Yes. Charles Lassiter with Mercer, and I've got my colleagues on the line if they want to jump in.

At the design phase of this demonstration we considered the rolling enrollment pattern, and for a couple of reasons we won't waive from that, namely the cost and the quality. We also wanted predictability in the enrollment for a period of innovation from the demonstration participants. I know something that we talked about early in the program that the defined participant list at the beginning gives you the type of runway for an individual to see a total intervention as opposed to individuals that enroll later for a period

of two, three months in the demonstration and then are included in the cost calculation. We have to convert that to some type of number per month effect of your interventions and then apply it in a way that's less direct and less -- it would correlate less with the actual impact that you had on an individual and instead probably incorporate more of a general trend which we take as the comparison.

And I'll pause there because I don't want to go too much further into the specifics of it. Just to say that we have evaluated that and if that is something that needs to be reconsidered we can talk to DSS about it.

BRAD HORMAN: Charles?

MR. LASSITER: Yeah, Brad, go ahead.

MR. HORMAN: This is Brad with Mercer. Just to add one other piece to that. Because of the way we measure quality looking at historical quality measures and looking at costs, having to look at historical

costs for each member, we would need to have some way of finding historical costs for each member that suddenly joined the program and for that reason due to the current design we're not able to take members that may have joined one of the participating entities in the last month because we need that historical data for them to see if there have been shared savings, to see if there has been improved quality, and for that reason we don't allow those members to join mid-year.

UNIDENTIFIED SPEAKER: When you say members, are you talking Medicaid beneficiary or provider member?

BRAD HORMAN: We'd be talking Medicaid beneficiary. For introducing provider members creates it creates a similar problem in that their historical data may or may not be part of your network if they were bought out from a different network.

So there's several complications there that the question remains, you know, to what extent is the program willing to change, to accommodate. I'm not

entirely sure what the number would be but how the many individuals that come either via new Medicaid enrollment or provider network acquisitions, understanding that for the advanced networks that's a reality the acquiring providers is a far larger reality.

MS. HANDLER: So this Sasha from Cornell Scott. So just to confirm for Wave 2 we're going to continue with assessing shared savings off of all of our assigned Medicaid members, no shift to attributed PCMH+ only.

MR. NORWOOD: Correct. So just a quick refresher, assigned numbers come from the attributed PCMH program, less excluded members. And that will remain the same in year two, and for the calendar year for purposes of the saving calculation for the contract year for purposes of the PMPM.

And this is Joel Norwood in DSS.

UNIDENTIFIED SPEAKER: Whoever, I think you should

please put yourself on mute. We're getting some background noise. Thank you.

MS. DANGREMOND: And this is Cate Dangremond again from Northeast Medical Group, Yale-New Haven Health.

Just one follow-on question that I think will be partially addressed through adding in the practices that I was referring to. But one question relative to quality metrics just to understand whether this has or hasn't been addressed in Wave 2. It wasn't clear entirely from the RFP.

We had a substantial issue in Wave 1 where we had, you know, more than double the number of people that were actually attributed to us, actually about three times the number of people that were actually attributed to us on PCMH+ who were actually part of our quality metric calculations. I know this was a known issue but something that we were very much hoping would be addressed in a way the quality calculations would be done in Wave 2 so that only attributed members were

part of those calculations.

Can you confirm whether that has been addressed in Wave 2?

MR. LASSITER: Charles Lassiter with Mercer. As of right now, no, we can confirm that it will remain the same, the same problems with drilling down to specific members and the quality data remains. At this point it is still such that participating in any of these, may see members that are not assigned in their quality data as well as practices also.

MS. DANGREMOND: Can you elaborate on that by chance even it if has to be at a later time? Because we're really struggling to be able to explain to our providers and to overcome some of the optics that that obviously creates. You know, we had 6,000 attributed members and 19,000-something in our portal for quality metrics. So I just would like (unintelligible) but that's still a substantial concern for us. Like I said, I hope some of adding these practices will help

with that, but if you can elaborate on what the challenges and the complication is and why we can't get the metrics drilled down just the attributed population, that would be quite helpful.

MR. LASSITER: Right. At present that's a CHN TIN issue. They just can't drill down past the TIN level for the quality of measures that are rolled up and how they receive them in their data set. We've explored a couple of possibilities, none of which will affect the ability to drill down and narrow that specific scoring measure to just the individuals assigned. We continue to look at that problem and see if there is a work-around that we can employ to get it a little bit less -- make it less or affects -- affect your quality score less. I mean the alternative would be to rearrange your TIN around this program, which -- right, I know, we're seeing laughter here.

(Voices speaking over each other.)

MR. LASSITER: Right. But besides that we just

don't have a work-around with CHN right now. But we do appreciate the problem that it creates and the possibility that it would dilute your quality score where a specific intervention is happening on a particular population.

As we go into the quality measure with you and the cost calculations we'll be considering those variables and seeing how the affect of that may actually play out if we could see it in our day-to-day. I'm sorry that we don't have more on that or a solution at this point but we do hear you and we do hear the frustration that it causes.

ROSE SWIFT: Hello, this is Rose Swift from Cornell Scott.

Is our letter for legacy organizations wishing to continue with -- due on February 2nd or February 26th?

MS. McDONOUGH: Actually it would be great if we had your letter of intent --

MR. NORWOOD: No, it's February 2nd.

MS. McDONOUGH: -- as soon as possible, but yes, like Joel said, it's February -- this is Marcia McDonough -- it is February 2nd, and it does say that in your contract extensions. Everyone will have a copy of their extension by next week.

MR. NORWOOD: Now and of course -- this is Joel Norwood, DSS. Just like with Wave 1 all participating entities including participating entities that participated in Wave 1 will enter into a new contract for Wave 2 anyway, so if after you've sent us the letter and we hope you all do, if you ultimately choose not to participate such as if there's new details that are elaborated later that you simply don't know by February 2nd, you can simply choose not to sign the contract for Wave 2.

So it's an initial step for us to start negotiating that. We have to contract with you and again of course we hope you all enter into it, but that's another opportunity for you to decide not to

participate if for whatever reason that's what you choose to do. So that letter is not a final commitment, if you will.

MS. ANDERSON: So this is Kirsten Anderson from the Value Care Alliance. And we just have a technical question. So the timing is that we have asked all these questions here and the answers will be formally posted on the 29th of January, and then do those answers form the basis for the contract? So you like send out -- do you correct the RFP or do you just add to that? I mean how do we --

MS. McDONOUGH: It depends on the questions we receive. If it is a correction or an edit to the RFP it will be posted as that.

MS. ANDERSON: Right.

MS. McDONOUGH: If it's something new information we post it as that. Until we get all the questions and sort them out and reflect back to the RFP it will all be done as an addendum to the RFP for all questions,

and all questions that were asked today will be also posted as an addendum to the RFP.

MS. ANDERSON: Thank you.

MS. McDONOUGH: You're welcome. As soon as possible.

MR. NORWOOD: Right. And Joel Norwood at DSS again. We understand the timing is tighter than we initially anticipated, and we fully realize that it wouldn't have been February 2nd, it would have been a later date, but again if -- we recommend that the most prudent thing to do would be to send that letter in as soon as possible well before February 2nd, and if you ultimately choose not to participate simply don't sign the contract for Wave 2.

MS. SWIFT: This is Rose Swift again for Cornell Scott. Are any attachments documenting that we need the requirements required or simply the letter?

MS. McDONOUGH: Right now it's the letter. And this is Marcia McDonough, sorry. The letter by

February 2nd or sooner if possible. Or like I said, if you sign the letter you can always opt out as it gets closer to the contract start date, after you get further information through the addendums to the RFP.

MR. LASSITER: And Marcia, is that cutoff date for adding practices in?

Do we know that yet?

MS. McDONOUGH: Well, the letter of intent -- I'm going to say by the proposal due date of February the 26th. That will give everybody -- it's a due date for all proposals in. It might be a due date for participating entities to make their decision. And like I said, when it -- so we know we want to get started on your contract, the end of February we all march to work on your contract, but towards the end, like I said, if -- when the proposals are due you should have all the information you need to decide if you want to go forward with the 4/1 contract start date.

MR. LASSITER: Also, the April assignment is made on the March attribution?

MS. McDONOUGH: Right.

MR. LASSITER: And March attribution happens I believe the beginning of the second week.

MS. GODBURN: Yes. So Nicole Godburn, DSS. So just echoing Marcia and Charles, let me just double check with CHN when their kind of like last date that they would need to know if you're changing your network structures would be that they would need all that information so that they can properly run your March attribution. I think they run it around the 10th or the 15th of the month. So I'm not sure if February 26th would give them enough time to put that together to run the proper list. So we'll just double check that date that you would need to get us all your practices that would be part of your network to us, and we'll get that out as soon as possible.

MR. NORWOOD: But certainly the sooner the better.

If you already have -- Joel Norwood, DSS -- if you already have that information I assume -- I defer to Marcia and Nicole, but I assume it would be in the same format you reported it initially, but whatever your updated structure is, new practices that you acquired or that were already part of your network and achieved PCMH status, again in the same format as you initially reported of ideally just rerun the entire thing so we have a completely up to date compilation of the composition of the network.

MS. GODBURN: Nicole Godburn, DSS.

So before I forget, so Misty from Generations, you had a question? And I want to make sure we address your question.

(No response.)

MS. GODBURN: I hope she's still with us. She may have left us.

So you want to open it up to questions?

MS. McDONOUGH: Yeah, for a little bit.

Does anyone else have any more questions? It is after 11:00.

MS. SCHINDO: Yes, this is Crystal from Northeast Medical Group.

I just wanted to confirm, it probably was stated earlier (unintelligible), I just want to confirm that in the contract it states that the advanced networks will not be receiving a PMPM. Or is that currently or is going to be reviewed further?

MS. McEVOY: This is Kate McEvoy, DSS. Regrettably we did not have the budget wherewithal to extend the supplemental payments to advanced networks. But what we understand from the SIM PMO is that the SIM PMO will intend to make grants to both the legacy participating entities and any new participating entities that are advanced networks and any new advanced networks that are selected through the procurement process, and we defer to our colleagues of the SIM PMO to ask if they would wish to comment

further on that.

MS. DOOKH: Hi, this Faina from the SIM Office. We are making additional CCIP transformation awards available to legacy participating entities as well as Wave 2 participating entities, and we are also making additional prevention service initiatives awards available as well to legacy participating entities and new applicants.

MS. YACAVONE: Hi, Kate, this is Kathy Yacavone. I know we're over time but I was corresponding with Nicole regarding transportation. If the new vendor could just send out to everybody its ECC (phonetic) information about contacts and the hotline and what rules and eligibility criteria they need to follow for booking transportation it would be very, very helpful. Thank you.

MS. McEVOY: Yes, thank you, Kathy. This is Kate McEvoy, DSS.

I want to acknowledge everyone's sharing of

information with us and patience through quite a challenging transition. We are very keenly on notice of the emerging issues around the call center volume, the transition, the accuracy of the transition data from LogistiCare to Veyo, challenges of fulfilling trips, and then the protocols for providers.

We're in active dialogue with Veyo on a constant basis about that and we will through Nicole, who is your lead liaison, be forwarding some additional information to clarify that.

Just so you are aware the lead individual for the Department as a liaison for NEMT (phonetic) is Rod, R-O-D, Winstead, W-I-N-S-T-E-A-D, Winstead. And like all of us the construction for state email is first name, Roderick, R-O-D-E-R-I-C-K dot Winstead, W-I-N-S-T-E-A-D at ct.gov.

If you wish to send observations or complaints directly, Rod is an entry point. But we do want to maximize sharing information with you that will

hopefully enable this process to work more smoothly. So Nicole will shortly be in touch on that.

MS. GODBURN: Nicole Godburn, DSS.

Yeah, Kathy, so I'm just working with Rod just to put together -- which I'll send to all the PCMH+ practices, basically just a one sheet of the phone number to call for care coordinators to arrange transportation, contact names. I'll throw Rod's info in there as well. Just basically a quick reference guide for the care coordinators to reference anything that's NEMT.

MS. YACAVONE: Thank you, Nicole.

MS. GODBURN: You're welcome, Kathy.

MS. McDONOUGH: If you could include that number for abandoned. So there was an emergency number that was added by Veyo. That would be a very useful number to have.

MS. GODBURN: Yes. Yeah, I heard that at MAPOC. I was present and listened, so I'm working with Rod to

put together all that information so we can shoot that to everybody.

JEANNE O'BRIEN: This is Jeanne O'Brien from VCA. This is a question in reference to the pendencies (phonetic) in the RFP. Do they need to be all resigned again for Wave 2 or are they just going to be rolled over?

MS. McDONOUGH: I think that most of the participating entities have already looked at that with the contract extension, and if you're not, you know, if you're past a year I'll refer you an email that I need your affidavits. But you don't have to resubmit unless you hear from me.

MS. O'BRIEN: Okay. Great. All right. Thank you, Marcia.

MS. McDONOUGH: Oh, you're welcome.

Anything else, anyone? We're going to wrap it up.

Now, would any one like to sign their intent right now or would you prefer to wait?

(Voices speaking over each other.)

UNIDENTIFIED SPEAKER: For everyone on the phone we're actually formally completing --

Thank you so much everyone. Have a great day.

MR. NORWOOD: It's now 11:08 and we're concluding the meeting.

(Proceedings concluded at 11:08 a.m.)

CERTIFICATE

I hereby certify that the foregoing 63 pages are a complete and accurate transcription to the best of my ability of the electronic recording of the PCMH+ Collaborative Meeting held before at the offices of the Department of Social Services, 55 Farmington Avenue, Hartford, Connecticut, on January 17, 2018.

Suzanne Benoit

State of Connecticut Department of Social Services Procurement Notice
Person-Centered Medical Home Plus Program, Wave 2,
Request for Proposals (PCMH+W2 RFP)

Suzanne Benoit, Transcriber Date: 2/5/18

Date Issued: February 7, 2018

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 Organization/Company

State of Connecticut Department of Social Services Procurement Notice
Person-Centered Medical Home Plus Program, Wave 2,
Request for Proposals (PCMH+W2 RFP)

The State of Connecticut Department of Social Services is issuing **Addendum 2** to the Person-Centered Medical Home Plus Program, Wave 2, Request for Proposals (PCMH+W2 RFP)

All requirements of the original RFP except those requirements specifically changed by this addendum shall remain in effect. In the event of any inconsistency between information provided in the RFP and information in this addendum, the information in this addendum shall prevail.

A. INFORMATIONAL LINK

The following link will take you to the Department's PCMH+ webpage.
http://portal.ct.gov/DSS/Health-And-Home-Care/PCMH-Plus/Documents

This link will provide you with:
Overview of Practice Transformation Supports for Providers and
Practice Transformation supports for Providers

B. QUESTIONS AND RESPONSES

1. **Question**: Would it be possible for the patient-attribution report to be run at the end of March instead of the beginning, thereby allowing additional time for patients to be recognized?

   Response: Member attribution reports are run on a pre-determined schedule that coincides with other Department activities and requirements. This schedule provides the Department with time to notify Medicaid members of their participation in PCMH+. This timeline also provides PEs the ability to review their member list, to begin the process of identifying PCMH+ members within the PE patient population and to begin patient outreach. For those reasons, it is not possible to run the attribution list for purposes of PCMH+ assignment later than early March.

2. **Question**: We understand the following statement was made on the recent bidders conference call: *"On the PCMH+ bidders conference call today DSS mentioned that there was funding available for FQHC's thru SIM."* We are wondering if you might be able to provide clarification specifically on the funding, the intent of the funding, or any other details that would help us understand this statement further.

Response: Please see Section III. PROGRAM INFORMATION F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 12. Community and Clinical Integration Program (CCIP) found on pages 42-43 of the RFP. This section outlines requirements for entities that wish to participate in receiving SIM funding. Additional information can be found at the SIM PMO website: http://www.healthreform.ct.gov

3. **Question**: Is the edge server a requirement?

   Response: Not applicable. That language has been removed from the RFP by Addendum 1.

4. **Question:** Will the PE be required to pay for the edge server and all associated expenses with setting it up?

   Response: Not applicable. That language has been removed from the RFP by Addendum 1.

5. **Question**: Will the edge server use SQL, Access or Centricity?

   Response: Not applicable. That language has been removed from the RFP by Addendum 1.

6. **Question**: The patient attribution will be made in March. Will the attribution period be April 1, 2018-December 31, 2019?

   Response: DSS plans to run the patient assignment (based on attribution) for each of the two calendar years of PCMH+ Wave 2, so the first assignment would be for April 1, 2018 through December 31, 2018 and the second assignment would be for January 1, 2019 through December 31, 2019.

7. **Question**: I'm writing on behalf of a federally qualified health center that was not a participant in PCMH Wave 1. (FYI we ARE a participant the DSS PCMH program and have received PCMH certification from the Joint Commission.)

   In order to decide whether to apply, we need to know how many of our Medicaid patients will be eligible for PCMH+, which according to p.27 of the RFP excludes patients in the following categories:

   a. Behavioral Health Home (BHH) participants.
   b. Partial Medicaid/Medicare dual eligible members; individuals participating in a Medicare Accountable Care Organization (ACO); and individuals enrolled in a Medicare Advantage plan.

c. Home and community-based services participants served under section 1915(c) waiver, section 1915(i), and section 1915(k).
d. Money Follows the Person (MFP) participants.
e. Residents of nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) and other long-term care institutions that are required to coordinate care for their residents.
f. Individuals enrolled in a limited benefit package (current limited benefits: family planning, breast and cervical cancer, and tuberculosis). g. Individuals receiving hospice services.
Can you provide us with a count of how many First Choice Medicaid patients are eligible (or how many satisfy one of a thru f)? If not can you suggest the easiest way to determine this number?

Response: DSS is happy to provide any prospective respondent to the RFP with information, as applicable, on its current number of individuals attributed to a practice for purposes of the PCMH program. As noted in the question, that figure does not take into account individuals who fall into one or more of the categories of individuals excluded from PCMH+. DSS is unable to provide specific information about the number of those individuals because that information will be determined at the time of actual patient assignment to each PCMH+ Participating Entity. As a rough estimate, because many individuals in the excluded categories may be HUSKY C Medicaid members, if a potential respondent excludes the HUSKY C members from its total, that may roughly approximate the number of PCMH+ eligible members. Final numbers will not be available until after the attribution has been run in early March 2018 and additional analysis has been completed to remove individuals from the list who fall within a category excluded from PCMH+.

8. **Question**: How do we know if we are good standing with Wave 1?

   Response: All current Wave 1 PEs are in good standing.

9. **Question**: Is there any more detail regarding the contemplated changes to the attribution methodology to account for patient attrition? We suggest that the changes keep the following issues in mind:
   a. Panel retention, given eligibility
   b. Panel engagement
      i. PCPs struggling with appropriate utilization of services (offering availability with patients choosing ED)
   c. Improved patient participation material to offer positive and collaborative provider-patient relationship

Response: Substantial detail is already included in the RFP itself (i.e., an individual will be restored to the assignment for purposes of care coordination add-on PMPM payments if the individual loses Medicaid eligibility but it is restored retroactively to continuous coverage within 120 days after the individual temporarily lost coverage). This policy is more flexible than the policy for wave 1 to reduce the impact of eligibility churn on the PCMH+ program. At the same time, the default needs to be that the program applies only to continuously eligible individuals to enable consistent care coordination services to be provided throughout the program year and to encourage participating entities to assist individuals in maintaining continuous coverage, which is one of many factors that helps to promote long-term health. Accordingly, DSS does not plan to make any other changes.

10. **Question**: Will claims data be available for Wave II, including behavioral health de-identified data?

    Response: DSS understands that a number of providers are seeking additional claims data to be able to run more detailed analytics and monitoring of their attributed members. DSS acknowledges the additional value that this data may provide to some participating entities. However, being able to appropriately and efficiently transmit this data in a manner that also complies with federal and state requirements, including applicable data confidentiality requirements is complex and time-consuming. DSS will notify providers if additional data becomes available, but for the present, that type of data is not currently available for transmission to providers.

11. **Question**: Will there be any change to the ICM program at CHN?

    Response: No

12. **Question**: We do not understand the automatic inclusion of Wave I participants in Wave II. As a Wave I participant, will we have the opportunity to negotiate regarding the terms of Wave II if we are automatically included?

    Response: Wave 1 participating entities are not required to respond to the Wave 2 RFP in order to minimize the administrative burden for both participating entities and DSS because those entities already complied with the full procurement process for Wave 1. Because a new contract will be necessary for ***all*** Wave 2 participants, any Wave 1 participant will have a comparable opportunity to negotiate the terms of the contract for Wave 2 as was available for negotiation of the Wave 1 contract.

13. **Question**: The Wave I contract was extended by 3 months. Will we see a reconciliation of Wave I data in 2018?

Response: Yes, the shared savings calculation results will be shared sometime before the end of calendar year 2018. Note that as detailed in the Wave 2 RFP, the Performance Year for purposes of analyzing both quality measures and cost/shared savings will remain on each calendar year, even though Wave 1 contracts were extended by three months.

14. **Question:** How many onsite and offsite audits are anticipated for Wave II?

    Response: Compliance reviews of Participating Entities generally will be conducted once per program year and may include an onsite component. More frequent reviews and audits may be conducted at DSS discretion to support appropriate oversight of the program.

    a. Clarification with Qualidgm/Mercer relationship and impact to advanced networks

    Response: Qualidigm is a contractor of the SIM PMO and was retained by the SIM PMO to evaluate one or more of its programs, including CCIP. Mercer is a contractor of DSS and works in partnership with DSS regarding a variety of activities for the PCMH+ program, including evaluation of participating entities.

    b. Clear articulation of program expectations: quality and utilization metrics versus the operational process reviewed by Mercer

    Response: Program expectations include both quality and utilization metrics and also operational processes. The reason the reviews in Wave 1 focused on operational process is because data on quality measures and full year cost data is not yet available. Due to claims lag, reporting time, and additional time for analysis, the 2017 data will begin to be available in mid-2018, with some data not completely available until the end of 2018. Technical assistance on program requirements will be provided during Wave 2 to Participating Entities. PEs will be notified of these sessions once finalized. DSS welcomes input from PEs on potential topic areas.

15. **Question**: When is the reconciliation for Wave II?

    Response: DSS anticipates performing the calculation and releasing shared savings results sometime before the end of calendar year 2018.

16. **Question**: Is there anything in the financial model that has changed from Wave I to Wave II?

    Response: For full details of the Wave 2 financial model, please review the RFP in detail (especially section III.F.7 on pages 35-39). For a brief informal summary of some

key selected changes, see Addendum 1 to the Wave 2 RFP. Although these are not the only changes, two changes that warrant particular attention are as follows: First, the "Improve Quality" scoring table will no longer be derived from a comparison group. The table will be derived from the quality improvement from all Participating Entities for each measure. This table is in section III.F.7.I.2. of the RFP (page 37). For FQHC Participating Entities, the Care Coordination Add-on payments will now be made retroactively for individuals who lose Medicaid eligibility but are retroactively restored to continuous coverage within 120 days after temporarily losing coverage, as further described in section III.F.7.a.i of the RFP (pages 35-36).

17. **Question**: What is an "edge server"? What technology will be provided to accomplish this?

    Response: Not applicable. That language has been removed from the RFP by Addendum 1.

18. **Question**: If a PE cannot financially support the technology to implement an 'edge server', what is the alternative? Clear additional state financial support to meet CT expectation for network interoperability.

    Response: Not Applicable. That language has been removed from the RFP by Addendum 1.

19. **Question**: How would the collection of data by an 'edge server' for SIM be restricted to just PCMH+ patients in the presence of such a server? How does population attrition affect the proposed collection of data? What is the anticipated timeframe for this data collection?

    Response: Not applicable. That language has been removed from the RFP by Addendum 1.

20. **Question**: If there is a security issue that precludes the installation of an "edge server", would we still be eligible for participation in Wave II?

    Response: Not applicable. That language has been removed from the RFP by Addendum 1.

21. **Question**: For Wave II participants who have been in Wave I, is there a requirement to submit additional documents such as Appendices F and G, or additional confirmation statements?

    Response: No.

22. **Question**: How do we inform DSS of additional PCMH certified practices? If a practice isn't PCMH certified by 4/1/18, would they be able to be retroactively added if they achieved recognition prior to 12/31/19? Shouldn't practices be recognized through the contract period to better offer access to CT Medicaid participants?

    Response: A Wave 1 participating entity would notify DSS of additional PCMH practices in writing through the Official Contact, which would also need to include a full updated description of the PCMH+ Participating Entity in the same format as provided in the Wave 1 RFP response. The reason only PCMH practices certified by March 1, 2018 (not April) is so that members attributed to that practice can be included in the attribution made in early March for purposes of assignment for April 1, 2018 through December 31, 2018. Adding practices in the middle of a measurement period is not possible in order to ensure continuity of PCMH+ care coordination services throughout the period for all members and to ensure fair comparison among the various participating entities. Additional PCMH practices can be added each time before attribution is run for purposes of assignment for a measurement period.

23. **Question**: When is the notification for Wave I participants regarding their acceptance into Wave II?

    Response: Wave 1 participating entities should send the Letter of Intent to continue the PCMH+ Wave 2 Program by 2/1/2018, close of business.

24. **Question**: If the attribution list for Wave II is generated on 4/1/18, when is that available to the participating entities?

    Response: The assignment list (based on attribution) will be provided as soon as the participating entity's Wave 2 contract has been signed (so long as the attribution and assignment have been determined at that time).

25. **Question**: What happens if a practice is awarded and begins the process at over 2500 patients, but over time that numbers drops below that threshold? What type of impact does that have on the agreement and/or payment structure?

    It appears, in our case, that number Medicaid currently attributed to us in our portal is below the 2500, however when we run it from our electronic medical record we seem to be meeting the target if after estimated exemptions are removed, however just barely, and we certainly would like to use the most correct number to be sure if we are hitting the target of 2500 or not.

    Response: As detailed on Page 14 of the RFP (section I.D.7.c.i), each respondent must have at least 2,500 PCMH+ eligible members attributed to it at the time it submits the RFP response. In practice, this figure will be determined as part of the PCMH+

assignment process based on the attribution in early March 2018, as modified based on analysis to remove individuals from the list who fall into a category excluded from PCMH+. After the assignment has been run, as long as the number listed in the final assignment for purposes of the April through December 2018 period, is at least 2,500, a Participating Entity may remain in PCMH+ throughout that performance period even if the number of individuals falls below 2,500 after the March assignment has been performed. For additional details on how to estimate the number of individuals who may be assigned to an entity, see the response to Question 22 above.

26. **Question**: Thank you for having the application TA conference yesterday. It was helpful. We did walk out with a question as to how to calculate our budget:

I think I heard it said that you would build your budget based upon the number of attributed Medicaid enrollees at a rate of $4.50 per month. Does that mean a formula calculation would work this way, assuming an organization has 5,000 attributed clients: 5,000 x $4.50 per member x 12 months = $270,000

- Would that $270,000 be the total amount of our one year budget?

Response: The Department is making no recommendation on how a PE is to build a budget and budget narrative, or how a PE should define costs associated with their PCMH+ program. PEs at a minimum must include all potential costs associated with your program. See section C. Budget and Narrative under Track 1 and Track 2 attachments located in the RFP. Based on your program design, funding streams, resources, and budget projections, your program costs may fall within the monthly PMPM amount or they may not. It is not necessary for your budget projections to match the monthly PMPM amount. Budget projections are unique to each program and assist the Department in understanding the financial commitments associated with your PCMH+ program.

Separately, Care Coordination Add-on Payments (Per-Member, Per-Month or PMPM) payments will only be made to FQHCs. Monthly PMPM payments are based on the total number of members for that month multiplied by $4.50. For example, if the monthly member count in June is 3,000. The total monthly payment for June is $13,500. (3,000 members in June multiplied by $4.50). Monthly member counts may change each month. Changes in the monthly member count may occur for various reasons, including if a member loses HUSKY eligibility and no longer qualifies for the benefit, a member moves out of state and is no longer eligible for Connecticut Medicaid, or a member meets the criteria for one of the exclusion categories and is removed from the PCMH+ program.

27. **Question**: Another budget-related question: Where in the application packet should the budget and budget justification be placed? There is no separate line item for it in the table of contents outline.

    Response: F. MAIN PROPOSAL, TRACK 1 IS ADVANCED NETWORK (AN) AND TRACK 2 IS FQHC.
    Both include 7. Financial Requirements. The budget and budget justification should be placed in that section just as you would respond to requirements throughout either TRACK. Audited Financial Statements shall be included with the "original" proposal.

28. **Question**: Procurement Notice: What happens if there is an addendum issued after our RFP response submission? Do we have to send an entire new proposal packet or can we address just the potential addendum change(s) occurring after our submission?

    Response: If that does occur, the DSS Official Contact will reach out to you and discuss at that time.

29. **Question**: Data and Outcome Monitoring:

    29. a. How will data and outcomes be monitored?

        Response: These details are currently under development. Additional detail will be provided as it becomes available.

    29. b. Are there any additional data collection/requirements or specific batching requirements required for this project?

        Response: These details are currently under development. Additional detail will be provided as it becomes available.

    29.c. What are the system requirements to transmit admission, discharge, transfer, and care summaries?

        Response: These details are currently under development. Additional detail will be provided as it becomes available.

    29. d .How are care summaries transmitted?

        Response: These details are currently under development. Additional detail will be provided as it becomes available.

29. e. Will all data and outcome results be retrieved from CHN/Claims Data/CareAnalyzer/Hedis measures or will we have to put data into a separate database?

Response: These details are currently under development. Additional detail will be provided as it becomes available.

29. f. How are enhanced care coordination activities tracked and monitored?

Response: We are tracking care coordination activities through participating entities' reports submitted to DSS, claims data, quality measure data, and other metrics.

29. g. What specific information should be tracked for reporting community partnerships to address social determinants of health?

Response: New PEs must submit a monthly PCMH+ report developed by the Department. (PEs who participated in Wave 1 must complete a quarterly report.) The report is designed to track the performance of the PCMH+ program within each PE, and requires the PEs to include a complete record of the community partnerships established as part of PCMH+. As a care coordination best practice and to help address social determinants of health, the Department encourages PEs to keep internal records regarding the community organizations and community services provided to their PCMH+ membership. Internal record keeping assists PEs with understanding the most effective and responsive organizations within their region that may be best able to partner with the PE to improve the health of PCMH+ members. Internal records also serve as a valuable resource for other care coordinators as they work to identify available community resources.

30. **Question**: CCIP:

30.a Can you tell us what is the time commitment from FQHCs in participating the CCIP program if you are also in the PTN program?

Response: Please see Section III. PROGRAM INFORMATION F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 12. Community and Clinical Integration Program (CCIP) found on pages 42-43 of the RFP. This section outlines requirements for entities that wish to participate in receiving SIM funding and are participating in the PTN program. Additional information can be found at the SIM PMO website: http://www.healthreform.ct.gov Please note that additional information regarding CCIP and PTN will be provided by the SIM PMO at the time of the CCIP RFP release. The CCIP RFP release is around or after the start of PCMH+ Wave 2 on April 1, 2018.

30. b. What is the $ amount per FQHC to offset costs of CCIP participation?

Response: Please see Community and Clinical Integration Program (CCIP) under section F. PCMH+ Program Description & Requirements of the RFP. This section outlines requirements for entities that wish to participate in receiving SIM funding. Additional information can be found at the SIM PMO website: http://www.healthreform.ct.gov Please note that CCIP funding award amounts will not be granted until after the start of PCMH+ Wave 2 April 1, 2018.

31. **Question**: Oversight Body Requirements: For an FQHC – can your FQHC Board of Directors or a committee of the Board of Directors that include consumers of our services be the Oversight Body?

Response: Yes, so long as the oversight body meets the requirements outlined in the RFP, it can be an existing body, such as the board of directors, a committee of the board of directors, or an advisory committee.

32. **Question**: On the RFP cover sheet, what is the CFDA number you are expecting applicants to list?

Response: Please provide your SSN/FEIN Number and your DUNS Number. Disregard the CFDA number.

33. **Question**: The RFP indicates that DSS would like two electronic copies of the proposal. Does this mean two copies on one CD? Or would you like two separate CD-ROMs each with one copy of the proposal?

Response: Two separate CD-ROMs each with one copy of the proposal are required.

34. **Question**: The RFP requests that the electronic copies of the proposal be compatible with Microsoft Office Word and only the required appendices and forms may be scanned and submitted in PDF format. Can an applicant submit one PDF file with the whole proposal (narrative and attachments)? Or is DSS looking for one Word document (the narrative) and a PDF of the scanned forms?

Response: Please note edit to copy. **The electronic copies of the submission shall be compatible with Microsoft Office Word.** For the electronic copies, only the required appendices and forms may be scanned and submitted in Portable Document Format (PDF) or similar file format. Flash drives are not acceptable.
The Department is looking for two electronic copies, compatible with Microsoft Office Word.

35. **Question**: On page 29 of the RFP, it states, "Non-DSS PCMH primary care practices within a Participating Entity may not receive a portion of any shared savings achieved by the entity." Does this preclude the following providers from receiving any shared savings achieved by an Advanced Network?

    Hospitals

    Specialists

    Behavioral health providers

    Oral health providers

    Response: This language simply means that a primary care practice within the Advanced Network may receive any shared savings only if the practice is a DSS PCMH practice (in other words, a primary care practice in the network that is not PCMH recognized may not receive any PCMH+ shared savings).

    However, this language does not preclude non-primary care providers from receiving any shared savings, including hospitals and specialists (which could include medical specialists as well as behavioral health and oral health providers). In short, behavioral health providers and oral health providers that are part of the Advanced Network may receive shared savings payments.

    Note that as required in the RFP, each Advanced Network respondent must detail in the RFP response its proposed distribution methodology for any shared savings payments that it may receive. If an entity is awarded the opportunity to negotiate a contract for PCMH+ Wave 2, the distribution methodology is subject to review and approval by DSS and will be documented in the contract.

36. **Question**: If an Advanced Network chooses to include specialists within its network, are there requirements on specific specialties that must be included in the network?

    Response: No.

37. **Question**: Are the "Recommended Technical Criteria for eCQM and CCD Data" listed on page 41 of the RFP required for only primary care practices, or all providers participating in an Advanced Network (including hospitals, specialists, behavioral health providers, oral health providers, etc.)?

    Response: That language was removed from the RFP by Addendum 1.

38. **Question**: May copies of the Respondent's three most recent annual financial statements (referenced on page 8 of "i. Attachment: Track 1 Main Proposal" be submitted in Portable Document Format (PDF)?

Response: Yes.

39. **Question**: Can a Preferred Provider Network (PPN) with an associated hospital network and an IPA act as the Advanced Network Lead Entity (ANLE)?

    Response: No, as stated in the RFP, the Advanced Network Lead Entity must be a participating provider in the Advanced Network and must be enrolled in Connecticut Medicaid. In that situation, the Advanced Network must choose one of its physician groups or hospitals to serve as the Advanced Network Lead Entity.

40. **Question**: On p.9 it says that the total funding available is "$4,295,303 for the contract period from April 1, 2018 through December 31, 2018; and $5,751,508 for PCMH+ W2 year two (January 1, 2019 through December 31, 2019)."

    40. a. Will this funding be divided only among new applicants to the PCMH+ program? Or will it be divided among both the original Wave 1 applicants and the new applicants?

    Response: Total funds are for the purpose of Care Coordination Add-on Payments (Per-Member, Per-Month or PMPM). Care coordination Add-on Payments will only be made only to FQHCs that participate in PCMH+. All FQHCs are eligible to receive Add-On Payments regardless if they are a new applicant, or a Wave 1 participant that wished to continue into Wave 2. Please see response below for how payment is calculated.

    40. b. How will the Care Coordination Add-On Payment per member per month (last year $4.50 I believe) be calculated? (For example, will it roughly be $4,295,303 divided by the number of PCMH+ members divided by 9 months?) Is it expected that it will be close to $4.50?

    Response: Care Coordination Add-on Payments (Per-Member, Per-Month or PMPM) payment will only be made to FQHCs. Monthly PMPM payments are based on the total number of members for that month multiplied by $4.50. For example, if the monthly members in June multiplied by $4.50). Monthly member counts may change each month. Changes in the monthly member count may be for a various reasons, including if a member loses HUSKY eligibility and no longer qualifies for the benefit, a member moves out of state is no longer eligible for Connecticut Medicaid, a member meets the criteria for one of the exclusion categories and is removed from the PCMH+ program, or if a member chooses to opt out of the PCMH+ program.

41. **Question**: In III.F.1 "Eligible Population" (p.27), categories of patients excluded from eligibility in PCMH+ are listed.
    Are we correct in understanding that we are not required to assess eligibility of our PCMH+ patients for each of these exclusion categories independently of CHNCT? We understand that patients who fall in these categories may not always be excluded by

CHNCT from the initial PCMH+ listing, but if not will be removed along the way in monthly updates from CHNCT.

Response: It is true that PCMH patients that fall into one of the exclusion categories will be excluded from PCMH+ member roster before the start of the program. Additionally, during Wave 2 CHNCT will run a monthly check of the PCMH+ member population for members that may meet the criteria for one of the exclusion categories. Participating entities are not required to do an independent verification to determine if an individual may have fallen into an excluded category.

42. **Question**: On p.28 (=III.F.2 (f)) it says "The appointment and removal of the clinical director and senior leader must be under the control of the oversight body."

This seems to require the CEO and the Board to cede important decision-making authority to the oversight body, for which there is no provision in the HRSA Health Center Compliance Manual. We suggest that the sentence be changed to: "Written reports and recommendations of the oversight body, which will include a substantial representation of PCMH+ members, will reflect the views of all members of the body, be subject to their approval, and be available to DSS for review." This ensures that the body can offer an independent assessment and guidance of the PCMH+ project without any conflict with HRSA governance guidelines.

Response: It was never the intention to conflict with HRSA rules or guidance; moreover, that sentence referred to the person charged as being clinical director and senior leader for purposes of PCMH+ only. However, upon further review, DSS realizes that this language causes confusion with the general purpose of the oversight body, which was never intended to conflict with the authority of organization's governing body to control the organization.

Accordingly, that sentence in Section III.F.2.f is revised as follows:

The participating entity must seek advice from the oversight body regarding appointment and removal of the clinical director and senior leader ~~must be under the control of the oversight body~~.

43. **Question**: In III.F.4(c) "Care Coordinator Staff Requirements" (p.33), it says:
"Requirements include:
i. Employ a full time care coordinator dedicated solely to care coordination activities.
ii. Assign care coordination activities to multiple staff within a practice.
iii. Contract with an external agency to work with the practice to provide care coordination."

This sounds like you're required to comply with (i), (ii), AND (iii). However, in 2 other places in the RFA (p.56 and 64), it says you have the option to choose among these 3 ways of satisfying care coordinator staff requirements – i.e. you're required to comply with (i), (ii), OR (iii). Is the latter what is meant here?

Response: The latter. The participating entity may choose to provide care coordination through any of those options (or a combination).
Accordingly, that language in Section III.F.4.c is revised as follows:

"Requirements include one or more of the following:"

44. **Question**: In III.F.12. "Community and Clinical Integration Program (CCIP)," concerning applicants to the CCIP program for which the RFP will soon be released, it says: "Entities participating in the PTN grant program will be required to participate in a learning collaborative and may have the opportunity to apply for small grants through SIM to support achievement of the Health Equity Improvement standard." As an FQHC participating in the PTN program, does this mean we are eligible at best for "small grants" through CCIP? Can you give us an indication of what CCIP funding we might be eligible for?

Response: Please see Community and Clinical Integration Program (CCIP) under section F. PCMH+ Program Description & Requirements of the RFP. This section outlines requirements for entities that wish to participate in receiving SIM funding and are participating in the PTN program. Additional information may be found at the SIM PMO website: http://www.healthreform.ct.gov. Please note that additional information regarding CCIP grant funding and PTN will be provided by the SIM PMO at the time of the CCIP RFP release. The CCIP RFP release is expected around or after the start of PCMH+ Wave 2 April 1, 2018.

45. **Question**: In III.F.2 "Organizational Requirements of PCMH+ Participating Entities" (p.27) there seems to be a discontinuity in the text. It says:

"These minimum submission qualification requirements are listed in

SECTION I. GENERAL INFORMATION:

Executive Summary,

D. PROPOSAL FORMAT 7. Minimum Submission Qualification Requirements, and are required of the Respondent to submit a proposal, AND

E. EVALUATION OF PROPOSALS 3. Minimum Submission Qualification Requirements"

I'm not sure how this should be parsed. There is no text followed by a period that might complete "are listed in" and, if these are references, E.3 has nothing to do with organizational requirements, I don't know what "Executive Summary" refers to, and the formatting is peculiar. Could you clarify this?

Response: To clarify: "These minimum submission qualification requirements are listed in *the following sections:*

SECTION I. GENERAL INFORMATION. D. PROPOSAL FORMAT
6. Executive Summary. In Section E. of its submission, Respondents must include a high-level summary, not exceeding two (2) pages, of the main proposal. This component of the proposal should demonstrate the Respondent's understanding of the requirements in this RFP and show how the Respondent will meet these requirements and measure the responses to the requirements. The Executive Summary should also describe any problems anticipated in meeting these requirements and how the Respondent will address these anticipated problems.
AND

SECTION I. GENERAL INFORMATION. D. PROPOSAL FORMAT
7. Minimum Submission Qualification Requirements, and are required of the Respondent to submit a proposal, AND

SECTION I. GENERAL INFORMATION. E. EVALUATION OF PROPOSALS
3. Minimum Submission Qualification Requirements"

46. **Question**: We understand the opportunity for an entity to apply as either an Advanced Network, or, as an FQHC.
Due to the participation minimum of 2,500 eligible Medicaid members for each entity, there are several FQHCs that are unable to apply. One possibly unintended result of the participation minimum is that several thousand Medicaid members will not be able to participate in the program simply because their attributed provider does not meet the threshold for participation. We would like to offer a potential solution that would eliminate the unintended participation issue and allow more Medicaid beneficiaries the opportunity to gain the benefits of PCMH+.

Our concept is this: we would like to create a new entity classification called an "Advanced Network of FQHCs" which would allow the pooling/aggregating of Medicaid beneficiaries attributed to FQHCs that do not meet the minimum participation requirements. This hybrid model accomplishes a number of the intended goals of DSS. First, it ensures that willing Medicaid members are given the opportunity to participate in the program. Second, by increasing the participation across another four or five FQHCs, there is benefit in the learning and other outcomes from a practice adopting new clinical

workflows and greater attention to the PCMH+ clinical measures which prepares them for future payment reform and value-based opportunities.

Our intent would be to have one of the FQHC members of the network serve as the lead agency and to contractually align the others to aggregate the membership accordingly. If DSS is so inclined, may we pursue this arrangement?
Response: DSS appreciates the intent behind this suggestion and the creativity involved in the suggestion. However, for the reasons described below, DSS declines to adopt this suggestion.

As previously stated in response to questions regarding the Wave 1 RFP, an FQHC that is a full (*i.e.*, non-Glide Path) participant in the DSS PCMH program has two options. If it meets the minimum requirements for an FQHC to participate in PCMH+ (including the minimum 2,500 PCMH+ eligible attributed members), then it may participate as a single FQHC.

Alternatively, an FQHC of any size that is a full participant in the DSS PCMH program may also be a primary care practice participant in an Advanced Network. If it chooses to participate as part of an Advanced Network, then all rules for Advanced Networks apply to that FQHC as a participant in the network, including the fact that Care Coordination Add-On Payments are not available to Advanced Networks. The reason for this rule is that it enables all Advanced Networks to be treated comparably. In addition, fiscal constraints also make it challenging to make PMPM payments available to FQHC-only networks. DSS also notes that Advanced Networks may be available for additional resources, such as from the SIM PMO, see above for more information.

47. **Question**: When will the responses to questions asked at the bidder's conference be available?

Response: Questions and responses from the conference as well as the PCMH+ Wave 1 contractor's meeting will be made available in a future addendum.

State of Connecticut Department of Social Services Procurement Notice
Person-Centered Medical Home Plus Program, Wave 2,
Request for Proposals (PCMH+W2 RFP)

Date Issued: February 2, 2018

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 Organization/Company

State of Connecticut Department of Social Services Procurement Notice
Person-Centered Medical Home Plus Program, Wave 2,
Request for Proposals (PCMH+W2 RFP)

The State of Connecticut Department of Social Services is issuing **Addendum 1** to the Person-Centered Medical Home Plus Program, Wave 2, Request for Proposals (PCMH+W2 RFP)

All requirements of the original RFP except those requirements specifically changed by this addendum shall remain in effect. In the event of any inconsistency between information provided in the RFP and information in this addendum, the information in this addendum shall prevail.

1. **III. PROGRAM INFORMATION F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS**

   6. Quality Strategy and Quality Measure Set is deleted in its entirety and replaced with the following:

   6. Quality Strategy and Quality Measure Set

   The Department's PCMH+ goals are to improve quality and the care experience of Medicaid members. The PCMH+ quality strategy, including a quality measure set (which includes measures of under-service and health care equity), will be used to evaluate PCMH+ PEs' performance and overall program success. The PCMH+ PE's ability to receive shared savings will be contingent on its quality score. For more information regarding the PCMH+ shared savings payment methodology, please refer to SECTION III. PROGRAM INFORMATION.F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 7. Overview of Payment Methodology.

   The Department's overall approach to addressing under-service is described in the draft document entitled "Under-Service Utilization Strategy", which is available at this link, PCMH+ Under-Service Utilization Monitoring Strategy. These strategies will continue to be expanded and refined.

   The current version of the PCMH+ quality measure set can be found in Attachment A of this RFP. Data for the majority of quality measures, including Healthcare Effectiveness Data and Information Set (HEDIS) measures, will be collected from PCMH+ Member claims and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Hybrid HEDIS measures (those

measures that can be collected using both administrative data and medical record abstraction) will only be evaluated using administrative data at this time, although in the future the Department intends to move towards medical record abstraction. Reporting measure(s) related to health care equity will be based on measures already on the scorecard. No additional reporting by the PEs is anticipated for health equity measures. Specifically, a measure or multiple measures will be adapted from current quality measures and used to assess differences in performance among a provider's patient groups based on race/ethnicity. The health equity measures will be reviewed with PEs before they are reported publicly and will include appropriate caveats regarding data validity. Quality measures used to determine shared savings payments in the Performance Year will be limited to these claims-based measures.

PCMH+ PEs will only receive a shared savings payment if they meet identified benchmarks on quality performance standards and measures of under-service. Providers will be disqualified from receiving shared savings if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality.

2. III. PROGRAM INFORMATION F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS

11. Recommended Technical Criteria for eCQM and CCD Data is <u>deleted in its entirety and replaced with the following</u>:

11. Agreement for Project Notify and Other Health IT Initiatives Administered by the Department

Each Participating Entity will be required to agree to the inclusion of the following or substantially similar provisions as part of the contract that will be entered into with the Department to participate in PCMH+ Wave 2:

A. The Participating Entity commits to the following:

1. Transmitting Admission, Discharge and Transfer ("ADT") Messages. To transmit admission, discharge, and transfer ("ADT") messages and other health alert notifications specified by DSS, and agreed to by the Participating Entity, in the following manner: (a) to DSS or its designee, (b) for all applicable health and other services performed by the Participating Entity for Connecticut Medical Assistance Program ("CMAP") members, (c) in real time, to the extent within the reasonable capabilities of Participating Entity, (d) in the manner and format agreed upon by DSS and the Participating Entity, and (e) using the version of Health Level 7 agreed upon by DSS and the Participating Entity ("HL7") and/or other message transport protocol(s) agreed upon by DSS and Participating Entity.

2. Transmitting Care Summaries. To transmit Continuity of Care Documents and any other related health information as specified by DSS, and agreed to by the Participating Entity, in the following manner: (a) to DSS or its designee, (b) for all applicable health and other goods and services performed or provided by the Participating Entity for CMAP members, and (c) in real time, to the extent within the reasonable capabilities of the Participating Entity, and (d) in the manner and format agreed upon by DSS and Participating Entity, including, but not limited to, use of Direct Messaging, use of HL7 Consolidated Clinical Document Architecture, and/or other standards agreed upon by DSS and the Participating Entity.

3. Transmitting Other Health Information. To transmit any health information required by DSS other than the information specified in paragraphs A.1 and A.2 of this section regarding CMAP members served by the Participating Entity, in the time, manner, and format agreed upon by DSS and the Participating Entity, provided that (i) such disclosure is permissible under applicable law; (ii) such disclosure is within the reasonable capabilities of the Participating Entity; and (iii) the disclosure would not constitute an undue financial burden to the Participating Entity.

4. Receiving Health Information. To receive, in the time, manner, and format agreed upon by DSS and the Participating Entity, all of the health information described in paragraphs A.1, A.2, and A.3 of this Agreement, which DSS or its designee sends to the Participating Entity.

5. Use of Health Information. With respect to health information received pursuant to paragraph A.4 of this section, to perform all actions required by DSS, such as any applicable care coordination activities that require use of such information, provided that such actions are permitted by law and are

consistent with the Participating Entity's professional obligations and standards of care.

B. DSS acknowledges and agrees that it will require any "designee" of DSS referenced in this agreement to complete the Participating Entity's then-current information technology security design review to the Participating Entity's reasonable satisfaction prior to performing any role or function hereunder and prior to receiving any health information from the Participating Entity in accordance with this section.

C. DSS and the Participating Entity may amend, modify, or cancel the provisions of this section, in whole or part, at any time in writing by mutual agreement.

D. On an annual basis, while this section remains in effect, DSS and the Participating Entity agree to evaluate each data feed or transmission established under this section, and terminate/discontinue any interface or data feed that has become obsolete or no longer provides value as agreed upon by DSS and the Participating Entity.

3. Informational purposes only:

Informal Draft Summary of Selected Person-Centered Medical Home Plus (PCMH+) Program Changes from Wave 1 Request for Proposals (RFP) to Wave 2 RFP

Updated as of January 17, 2018

NOTE: This informal draft summary of selected changes was prepared only for readers' convenience. It is a summary only and does not change any provision of the RFP, nor is it a full summary of all changes. Please review the RFP text carefully (including any modifications to the RFP by one or more addenda). Page numbers refer to the pagination in the initial RFP.

Page 15 – Under-service Prevention Requirements (Section I.D.7.c.iv.5): Additional details added regarding PEs' necessary actions to monitor, identify, and prevent under-service.

Pages 35-39 – Overview of Payment Methodology (Section III.F.7): Various changes made to update the payment methodology both for care coordination add-on payments and also the shared savings payments. Review the entire section for the updated details. Among these changes include, but are not limited to, Care Coordination Add-On Payments being made to FQHC PEs for individuals assigned to the FQHC who are otherwise eligible for PCMH+, then lose eligibility for Medicaid but are reinstated retroactively to continuous enrollment no later than 120 days after temporarily losing enrollment.

Pages 39-40 – Monitoring and Reporting (Section III.F.8): Monthly reports will continue in Wave 2, but will be required quarterly instead of monthly for existing PEs.

Page 40 – Year End Report (Section III.F.9): Year-end report now required after the close of each performance year.

Pages 40-41 – Linkages with Community Partners to Address Social Determinants of Health (Section III.F.10): Additional requirements added for PEs to sponsor local collaborative forums or participation in existing collaborative forums.

Pages 41-42 – Electronic Data Sharing (Section III.F.11): The language in the initial RFP was deleted and replaced the language specified above in Addendum 1 to the RFP.

State of Connecticut Department of Social Services Procurement Notice
Person-Centered Medical Home Plus Program, Wave 2,
Request for Proposals (PCMH+W2 RFP)

Date Issued: January 17, 2018

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 Organization/Company

State of Connecticut Department of Social Services

PROCUREMENT NOTICE

Person-Centered Medical Home Plus Program, Wave 2,
Request for Proposals (PCMH+W2 RFP)

The State of Connecticut Department of Social Services (Department or DSS) is requesting proposals from qualified Federally Qualified Health Centers and Federally Qualified Health Center Look-Alikes (collectively, FQHCs) and Advanced Network Lead Entities (on behalf of Advanced Networks) to become Participating Entities (PEs) in the Department's **Person-Centered Medical Home Plus Program,** Wave 2 (PCMH+ W2).

IMPORTANT NOTE: All Participating Entities (both Advanced Networks and FQHCs) that participated in PCMH+ Program, Wave 1, (PCMH+ W1) will be rolled over into participation in the PCMH+ W2, for a project period beginning April 1, 2018 and running through December 31, 2019, without being required to respond to this RFP, so long as they comply with all applicable requirements of PCMH+ W2, comply with all requirements contained within this RFP, and have notified the Department of their intent to participate in PCMH+ W2 in accordance with the terms of the amendment to their contract for PCMH+ W1.

The Department is excited to offer this opportunity to new applicants. PCMH+ W1 demonstrated important progress in expansion of care teams, integration of behavioral health, use of the PCMH data portal in support of coordination of services for members, and launch of a working provider collaborative. PCMH+ W2 will continue to improve health outcomes and the care experienced by Medicaid members and contain the growth of health care costs. Selected FQHCs and Advanced Networks will provide care coordination activities to improve the quality, efficiency, and effectiveness of care delivered to Medicaid members.

PCMH+ Participating Entities that are FQHCs will receive a Care Coordination Add-On Payment paid prospectively on a monthly basis for Care Coordination Add-On Payment Activities that the FQHC will provide to PCMH+ Members. If a PCMH+ Participating Entity meets specified quality performance standards, including under-service prevention requirements, and generates savings for the Connecticut Medicaid program, then that PCMH+ Participating Entity will receive a payment calculated using a shared savings methodology as described in SECTION III. PROGRAM INFORMATION.F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 7. Overview of Payment Methodology of this request for proposal (RFP). This initiative involves upside only risk. PCMH+ Participating Entities will not be required to return any share of increased expenditures incurred by Connecticut Medicaid.

Minimum Qualifications of Respondents. To be considered eligible to respond to this RFP, an organization must be an enrolled Connecticut Medicaid provider, and meet the additional minimum qualifications of a FQHC or an Advanced Network as specified in SECTION I.GENERAL INFORMATION, D. Proposal Format 7. Minimum Submission Qualification Requirements of this RFP.

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

The PCMH+ W2 RFP offers two (2) tracks for responses to PCMH+ Wave 2 requirements. Both tracks are provided as attachments to this RFP.

Track 1: ADVANCED NETWORK (AN) Proposal Requirements for FIRST TIME RESPONDENTS to the PCHM+ Program, Wave 2, (PCMH+W2)

Track 2: FEDERALLY QUALIFIED HEALTH CENTER (FQHC) Proposal Requirements for FIRST TIME RESPONDENTS to the PCHM+ Program, Wave 2, (PCMH+W2)

General Procurement Information. A RFP Conference will be held on **January 18th, 2018.**

The deadline for submission of proposals is 2:00 pm Eastern Time on **February 26, 2018**

Proposals received after the stated due date and time may be accepted by the Department as a clerical function, but will not be evaluated. Those proposals that are not evaluated can be picked up by the Respondent after notification from the Official Contact or will be retained for thirty (30) days after the resultant contracts are executed, after which time the proposals will be destroyed.

The RFP is available in electronic format on the State Contracting Portal at http://www.biznet.ct.gov/SCP_Search/Default.aspx? under Social Services or from the Department's Official Contact:

Name:	Marcia McDonough, Contract Administration
Address:	State of Connecticut, Department of Social Services 55 Farmington Ave. 12th Floor, Hartford, CT 06105-3730
Phone:	(860) 424-5214
Fax:	(860) 424-5800
Email:	Marcia.McDonough@ct.gov

The RFP is also available on the Department's website at:
http://portal.ct.gov/DSS/Services/Partners-andVendors/RFPs

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

I. GENERAL INFORMATION

A. INTRODUCTION

1. **Request for Proposal Name.** Person-Centered Medical Home Plus Program, Wave 2, Request for Proposals (PCMH+W2 RFP)

2. **Summary.** The State of Connecticut Department of Social Services (Department or DSS) seeks to contract with Federally Qualified Health Centers and Federally Qualified Health Center Look-Alikes (collectively, FQHCs) and Advanced Network Lead Entities (on behalf of Advanced Networks) to become PCMH+ Participating Entities (PEs). The goal of PCMH+ W2 is to continue to improve quality and the care experience of Medicaid members.

The Department is excited to continue the Connecticut Medicaid PCMH+ Program, which is one of the priorities of Connecticut's State Innovation Model (SIM) Model Test grant. PCMH+ amplifies the important work of the Connecticut Medicaid PCMH program. As of December, 2017, 114 practices (affiliated with 477 sites and 1,695 providers) are participating in the PCMH program, serving 358,326 members (47% of Medicaid members). Connecticut's Medicaid PCMH program represents strong roots for PCMH+. PCMH practices have adopted practices and procedures designed to enable access to care; developed limited, embedded care coordination capacity; become attuned to use of data to inform responses to their panel members; and also have become attentive to working within a quality framework. Further, they have demonstrated year-over-year improvement on a range of quality measures and have received high scores on such elements as overall member satisfaction, access to care, and courtesy and respect. Notwithstanding, there remains a number of areas in the quality results that illustrate ongoing opportunities for improvement. These have informed both the care coordination approach and quality measure framework for PCMH+. PCMH+ has also enabled DSS to begin migrating its federated, Administrative Services Organization-based Intensive Care Management (ICM) interventions to more locally based care coordination. While the ASO ICM will continue to wrap around PCMH+ efforts in support of individuals with highly specialized needs (e.g. transplant, transgender supports), PCMH+ underscores DSS' commitment to provide practice coaching and funding supports to local entities that have the experience and trust basis to effectively serve their communities. PCMH+ has also been aligned with the SIM Clinical and Community Integration Program (CCIP), and the Center for Medicare and Medicaid Innovation (CMMI) Transforming Clinical Practice Initiative (TCPI) grant in which the Community Health Center Association of Connecticut is participating. Finally, PCMH+ represents the first ever Connecticut Medicaid use of an upside-only shared savings model approach. This has brought DSS along the curve of value-based payment approaches, which until recently have focused exclusively on Category 2C Health Care Payment Learning & Action Network (HCP-LAN) Alternative Payment Models (APM) rewards for performance.

Respondents to this RFP are encouraged to be innovative in how they explain how they plan to meet the requirements of this RFP, including incorporating their own insights, experience, and creativity in the shared goals of improving Connecticut's Medicaid program. The Department has been purposeful in avoiding a prescriptive approach to fulfilling the required care coordination activities, and expects and invites Respondents to detail how they intend to fulfill them.

To the above ends, PCMH+ W2 is guided by a number of important values:

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

All Connecticut Medicaid members will be eligible for assignment to PCMH+ PEs, with the exception of individuals who already receive extensive care coordination via other state and federal programs, or who have another source of health care coverage or a limited Medicaid benefit. The Department's goal is to assign approximately 200,000 Medicaid members to PCMH+ Participating Entities selected through this procurement.

PCMH+ PEs that are FQHCs will receive a Care Coordination Add-On Payment paid prospectively on a monthly basis for Care Coordination Add-On Payment Activities that the FQHCs will be required to provide to PCMH+ Members.

If a PCMH+ PE generates savings for the Connecticut Medicaid program and also meets specified quality performance standards, including under-service prevention requirements, the PE will share in the savings achieved. There will be no downside risk for PCMH+ PEs, meaning that PCMH+ PE will not be required to return any portion of increased expenditures incurred by Connecticut Medicaid. Additional information regarding payments under PCMH+ can be found in SECTION III. PROGRAM INFORMATION.F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 7. Overview of Payment methodology of this RFP.

Contracts for PCMH+ PEs selected through this procurement are expected to begin on April 1, 2018 and run through December 31, 2019. For that time period, FQHCs and Advanced Networks will provide Enhanced Care Coordination Activities as defined in SECTION III. PROGRAM INFORMATION.F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS.4. Enhanced Care Coordination Activities. PCMH+ PEs that are FQHCs will provide Care Coordination Add-On Payment Activities, and the Department will make Care Coordination Add-On Payments to PCMH+ PEs (described in SECTION III. PROGRAM INFORMATION.F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 7. Overview of Payment methodology).

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

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

■ B. ABBREVIATIONS/ACRONYMS/DEFINITIONS

1. Abbreviations/Acronyms

ACO	Accountable Care Organization
ADA	Americans with Disabilities Act of 1990
ASO	Administrative Services Organization
BFO	Best and Final Offer
C.G.S.	Connecticut General Statutes
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCIP	Community and Clinical Integration Program
CHRO	Commission on Human Rights and Opportunities (CT)
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare & Medicaid Services (U.S)
CMM	Comprehensive Medication Management
CMMI	Center for Medicare & Medicaid Innovation (U.S.)
CT	State of Connecticut
CYSHCN	Children and Youth with Special Health Care Needs
Department	State of Connecticut Department of Social Services
DAS	Department of Administrative Services (CT)
DME	Durable Medical Equipment
DSS	State of Connecticut Department of Social Services
FOIA	Freedom of Information Act (CT)
FQHC	Federally Qualified Health Center or Federally Qualified Health Center Look-Alike
HEDIS	Healthcare Effectiveness Data and Information Set
HRSA	Health Resources and Services Administration (U.S.)
LOI	Letter of Intent
LTSS	Long-term Services and Supports
MMIS	Medicaid Management Information System
PCMH+	Person-Centered Medical Home Plus Program
NCQA	National Committee for Quality Assurance
OAG	Office of the Attorney General (CT)
OPM	Office of Policy and Management (CT)
PCMH	Person-Centered Medical Home
PHSA	Public Health Service Act
PMO	Project Management Office
POS	Purchase of Service
PTN	Practice Transformation Network Grant Program
RFP	Request for Proposals
SEEC	State Elections Enforcement Commission (CT)
SHIP	State Healthcare Innovation Plan
SIM	State Innovation Model
State	State of Connecticut
TAY	Transition Age Youth
U.S.	United States
WRAP	Wellness Recovery Action Plan

2. Definitions

Advanced Network	A provider organization or group of provider organizations that provide Enhanced Care Coordination Activities to PCMH+ Members. At a minimum, an Advanced Network must include a practice currently participating in DSS' PCMH program (other than a Glide Path practice). Acceptable options for Advanced Network composition include: 1. One or more DSS PCMH practice(s); 2. One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health and oral health providers; 3. One or more DSS PCMH practice(s) plus specialist(s) (which could include physical health, behavioral health and oral health providers) and one or more hospital(s); or 4. A Medicare Accountable Care Organization (ACO) that includes one or more DSS PCMH practice(s). Please Note: This definition is unique to PCMH+ and differs from the general Connecticut SIM definition of Advanced Network. For purposes of PCMH+, the Advanced Network must meet the definition described above but, unlike the general SIM definition, is not required to have risk-bearing contracts for providing health services.
Advanced Network Lead Entity	A provider or provider organization that contracts with the Department on behalf of the Advanced Network and fulfills the functions specified in Section III.F. The Advanced Network Lead Entity must be a participating provider in the Advanced Network.
Attribution	Members are attributed based on PCMH logic. Quarterly, CHNCT runs a PCP/PCMH attribution report utilizing claims and supplemental data criteria retro 15-months. The 15-month claims look back for the member's usual source of care based on claims data. A member who has self-selected a provider as their PCP will remain with that provider until another self-selection is made or claims indicate a different PCP. If a member is not attributed due to a lack of claims, and has not self-selected a PCP/PCMH, they will remain unassigned for the attribution cycle.
Care Coordination Add-on Payments	Payments paid prospectively on a monthly basis to PCMH+ Add-On Payment Participating Entities that are FQHCs for providing Care Coordination Add-On Payment Activities to PCMH+ Members.
Care Coordination Add-on Payment Activities	Care coordination activities that PCMH+ Participating Add-On Payment Entities that are FQHCs will be required to provide to PCMH+ Members in order to receive the Care Coordination Add-On Payment. The Care Coordination Add-On Payment Activities are in addition to the Enhanced Care Coordination Activities required of all PCMH+ Participating Entities.
Contractor	See PCMH+ Participating Entity
Contract	The Contract awarded to the successful Respondents pursuant to this RFP.
Day	Calendar Day
Enhanced Care Coordination Activities	Required care coordination activities that all PCMH+ Participating Entities must provide. These activities are described in Section III.F.4 of this RFP.

Federally Qualified Health Center	An entity that meets the definition of an FQHC in section 1905(l)(2)(B) of the Social Security Act and meets all requirements of the HRSA Health Center Program, including both organizations receiving grants under Section 330 of the Public Health Service Act and also FQHC Look-Alikes, which are organizations that meet all of the requirements of an FQHC but do not receive funding from the HRSA Health Center Program.
PCMH+ Member	Medicaid members prospectively assigned to PCMH+ Participating Entities using the Department's PCMH retrospective attribution process, which has been adapted for PCMH+.
PCMH+ Participating Entity	An FQHC or Advanced Network (represented by the Advanced Network Lead Entity) contracted by the Department to participate in PCMH+. Also referred to as Contractor.
PCMH+ Quality Measures	The set of quality measures used to evaluate the performance of PCMH+ Participating Entities and the performance of the PCMH+ as a whole. Specific quality measures may be for reporting purposes only, or may be utilized to calculate an PCMH+ Participating Entity's quality performance as part of the shared savings calculations. The current version of the PCMH+ quality measure set can be found in Attachment A of this RFP, which is subject to change by the Department.
Performance Year or Performance Period	This is the time period that the performance of the PCMH+ Participating Entities will be evaluated for the purpose of the shared savings calculation.
Prior Year	The time period preceding the Performance Year for purposes of establishing the PCMH+ Participating Entities' cost baseline and quality measure benchmarks.
Prospective Respondent	A provider organization that may submit a proposal to the Department in response to this RFP, but has not yet done so.
Official Contact	The DSS staff person who serves as Respondents' sole point of contact regarding this RFP. The Official Contact for this RFP is Marcia McDonough.
Respondent	A provider organization (FQHC or Advanced Network Lead Entity on behalf of an Advanced Network) that has submitted a proposal to the Department in response to this RFP.
Subcontractor	An individual (other than an employee of the Contractor) or business entity hired by a Contractor to provide a specific service as part of a Contract with the Department as a result of this RFP.
State Innovation Model	An initiative created by the Center for Medicare & Medicaid Innovation (CMMI) to provide financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that is designed to improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program members - and for all residents of participating states. For additional information, see https://innovation.cms.gov/
Transition Age Youth	Commonly defined as individuals between the ages of 16 and 25 years. The age range for transition age youth (TAY) can vary to include children as young as 12 years of age.
Under-service, continued below	Under-service means actions taken by or on behalf of a Participating Entity that have the result of limiting, excluding or discouraging one or more members from seeking or receiving medically necessary

	Medicaid covered services, including actions taken with the express or implicit goal of increasing savings generated by the Participating Entity, reducing the number of high-risk members assigned to the Participating Entity or both.

■ C. INSTRUCTIONS

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

   Name: Marcia McDonough, Contract Administration
   Address: State of Connecticut, Department of Social Services
   55 Farmington Ave. 12th Floor, Hartford, CT 06105-3730
   Phone: (860) 424-5214
   Email: Marcia.McDonough@ct.gov

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

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

   - Department's RFP Web Page: http://portal.ct.gov/DSS/Services/PartnersandVendors/RFPs
   - State Contracting Portal: http://www.biznet.ct.gov/SCP Search/Default.aspx? under Social Services

   It is strongly recommended that any Respondent or Prospective Respondent interested in this procurement subscribe to receive email alerts from the State Contracting Portal. Subscribers will receive a daily email announcing procurements and addenda that are posted on the portal. This service is provided as a courtesy to assist in monitoring activities associated with State of Connecticut procurements, including this RFP. Printed copies of all documents are also available from the Official Contact upon request.

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

   Total Funding Available: $4,295,303 for the contract period from April 1, 2018 through December 31, 2018; and $5,751,508 for PCMH+ W2 year two (January 1, 2019 through December 31, 2019). Each of these amounts represents the state and federal share combined of the Care Coordination Add-On Payments to FQHCs. This amount does not include the state or federal share of any shared savings payments.

Number of Contracts:	Up to the total number of qualifying FQHCs and Advanced Networks. The Department will not limit the number of qualifying Respondents from being selected as PCMH+ Participating Entities.
Contract Cost:	To be determined in accordance with the methodology for shared savings payments and care coordination add-on payments, if applicable, as described elsewhere in this RFP.
Contract Term:	April 1, 2018 through December 31, 2019.

The Department reserves the right to amend the contract period for any reason determined to be necessary by the Department, including, but not limited to, ensuring that payments remain within available appropriations and that the Department has received sufficient federal approval to obtain federal matching funds for such appropriations.

4. **Eligibility.** To be considered eligible to respond to this RFP, an organization must be an enrolled Connecticut Medicaid provider and meet the minimum submission qualifications of a FQHC or an Advanced Network as specified in SECTION I.GENERAL INFORMATION, D. Proposal Format 7.Minimum Submission Qualification Requirements of this RFP.

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

   The PCMH+ W2 RFP offers two (2) tracks for responses to PCMH+ W2 RFP requirements.

   <u>TRACK 1</u>: ADVANCED NETWORK (AN) Proposal Requirements for FIRST TIME RESPONDENTS to the PCHM+ W2

   <u>TRACK 2</u>: FEDERALLY QUALIFIED HEALTH CENTER (FQHC) Proposal Requirements for FIRST TIME RESPONDENTS to the PCHM+ W2

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

   - RFP Released: January 8, 2018
   - RFP Conference: January 18, 2018
   - Deadline for Questions: January 22, 2018, 2:00 PM EST
   - Answers Released: January 29, 2018 (tentative):
   - Letter of Intent (LOI) Due: February 5, 2018 2:00 PM EST
   - Proposals Due: February 26, 2018 PM EST
   - Start of Contract*: April 1, 2018

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

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

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

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

   - Date: January 18, 2018
   - Time: 11:00 am until 1:00 pm
   - Location: DSS Central Office, 55 Farmington Avenue Hartford CT 06105

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

    - Due Date: February 26, 2018
    - Time: 2:00 pm Local Time

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

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

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

    An acceptable submission must include the following:

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

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

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

■ D. PROPOSAL FORMAT

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

2. **Cover Sheet.** The Cover Sheet, embedded as a hyperlink is Page 1 of the proposal.

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

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

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

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

6. **Executive Summary.** In Section E. of its submission, Respondents must include a high-level summary, not exceeding two (2) pages, of the main proposal. This component of the proposal should demonstrate the Respondent's understanding of the requirements in this RFP and show how the Respondent will meet these requirements and measure the responses to the requirements. The Executive Summary should also describe any problems anticipated in meeting these requirements and how the Respondent will address these anticipated problems.

7. **Minimum Submission Qualification Requirements.** Respondents must include the Executive Summary response, immediately above, as well as the following requirements, appropriate to a FQHC or an Advanced Network.

   a) ***Federally Qualified Health Center (FQHC) Supporting Documentation*** – Provide the following documentation applicable to your organization as **Appendix A, *FQHC Supporting Documentation***.

i. Provide documentation that reflects receipt of HRSA grant funding under Section 330 of the PHSA or for FQHC Look-Alikes, provide documentation that HRSA has designated the entity as an FQHC Look-Alike.

ii. Provide official communication from DSS documenting the participation of the FQHC as a participant in the DSS PCMH program.

iii. Provide documentation that reflects receipt of Level 2 or Level 3 Patient-Centered Medical Home recognition from NCQA or Primary Care Medical Home certification from The Joint Commission.

b) ***Advanced Network (AN) Lead Entities Supporting Documentation*** – Provide the following documentation applicable to your organization as **Appendix B**, ***Advanced Network Lead Entity Supporting Documentation***.

i. Provide official communication from DSS documenting the participation of each of the providers within the Advanced Network that are a PCMH practice in the DSS PCMH program. (At least one provider in the Advanced Network must currently participate as a PCMH in the DSS PCMH program.)

ii. Provide for Advanced Network Lead Entities submitting proposals for Advanced Networks that are Accountable Care Organizations (ACOs) as that term is defined in the Medicare Shared Savings Program, provide a copy of the official communication from CMS documenting the Respondent's participation as an ACO in the Medicare Shared Savings Program.

iii. Provide for Advanced Network Lead Entities, a description and accompanying supporting documentation to show that the Advanced Network Lead Entity is authorized to participate in this RFP on behalf of the Advanced Network, is authorized to enter into a potential contract as an PCMH+ Participating Entity on behalf of the Advanced Network, and has the ability to ensure that the Advanced Network complies with all applicable requirements, including, but not limited to all of the PCMH+ Participating Entity provider qualifications for Advanced Networks.

c) To qualify for participation in PCMH+ W2, each PCMH+ PE, FQHC or Advanced Network is required to provide statements acknowledging that its organization adheres to the requirements listed below. Provide the following Acknowledgement Statements as **Appendix C, *Acknowledgment Statements.***

i. At the time of submitting the response to this RFP, have at least 2,500 DSS PCMH Program attributed members who are eligible to participate in PCMH+ and who are not in an excluded category of members. Respondents may request informal information on their attributed members from the Department's Official Contact in writing by February 12, 2018. The Department's Official Contact will respond in writing to confirm the number of attributed PCMH members and also which practices within the Participating Entity are PCMH recognized as of that date. If practices do not meet requirements for minimum level of attributed members and/or PCMH recognized practices by February 12, 2018, then members will not be assigned during the performance year, but may be reevaluated in later performance years.

ii. Require any non-DSS PCMH primary care practices within the Advanced Network or FQHC sites that do not yet have PCMH status or PCMH accreditation, to achieve PCMH status or PCMH accreditation, not less than eighteen months after the start of the PCMH+ performance period. DSS may extend this timeframe for PCMH recognition based on good cause outside of the participating entity's control.

If one or more practices or FQHC sites within a participating entity does not meet the requirement, the department shall issue a corrective action plan to the participating entity. The target date for a primary care practice to complete these steps within a Participating Entity that participated in PCMH+ Wave 1 (calendar year 2017) is June 30, 2018. The target date a primary care practice to complete these steps within a Participating Entity that is participating in PCMH+ for the first time in PCMH+ Wave 2 is October 31, 2019. Additional information about the DSS PCMH program, including resources and supports for practices on the Glide Path can be found at the HUSKY Health Person-Centered Medical Home website.

iii. Ensure that only providers enrolled in Connecticut Medicaid are providing Medicaid services to PCMH+ Members (link to Connecticut Medical Assistance Program Provider Enrollment website).

iv. Have an oversight body that may, but is not required to, overlap with an existing governing board or an existing advisory body. The oversight body must include substantial representation by PCMH+ Members assigned to the PCMH+ PE and at least one provider participating in the PCMH+ PE. The type and number of providers on the oversight body need not be proportional to PCMH+ PE participating providers, but must be representative of the variety of providers participating in the PCMH+ PE (e.g., primary care, other physical health providers, behavioral health providers, oral health providers, etc.). The oversight body must:

(1) Meet at least quarterly and provide meaningful feedback to the PCMH+ PE on a variety of topics, including quality improvement, member experience, prevention of underservice, implementation of PCMH+, and distribution of shared savings.

(2) Have a transparent governing process.

(3) Have bylaws that reflect the oversight body's structure as well as define its ability to support the PCMH+ objectives.

(4) Have a conflict of interest policy calling for disclosure of relevant financial interests and a procedure to determine whether conflicts exist and an appropriate process to resolve conflicts.

(5) Under-service Prevention Requirements: Have or develop a means to monitor, identify and address under-service. There is a potential risk in a shared savings model that members are diverted from a provider practice or discouraged from medically necessary services in an effort to drive increased savings or limit the number high-risk members a provider may serve. In response to this potential risk, it is important that PEs develop an approach designed to monitor, and identify potential under-service utilization or inappropriate reductions in access to medically necessary care that includes prohibiting these practices and educating staff.

d) Advanced Networks must, at a minimum, provide a Confirmation Statement that the Advanced Network complies with the two (2) requirements listed below. Provide the Confirmation as **Appendix D, *Advanced Network Confirmation***.

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

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

e) FQHCs must, at a minimum, provide a Confirmation Statement that the FQHC complies with the five (5) requirements listed below. Provide the Confirmation as **Appendix E, *FQHC Confirmation***.

i. Meet all requirements of an FQHC under section 1905(l)(2)(B) of the Social Security Act,
ii. Have either: (A) HRSA grant funding as an FQHC under Section 330 of the PHSA or (B) HRSA designation as an FQHC Look-Alike.
iii. Operate in Connecticut and meet all federal and state requirements applicable to FQHC.
iv. Be a current participant in the DSS PCMH program (Glide Path practices are excluded) and hold current Level 2 or 3 Patient-Centered Medical Home recognition from NCQA or Primary Care Medical Home certification from The Joint Commission.

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

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

Binding Type:	Loose-leaf binders with the Legal Name of the Respondent, and the RFP Name appearing on the outside front cover of each binder: **Person-Centered Medical Home Plus Program, Wave 2 (PCMH+ W2)**. **PCMH+ W2 is acceptable**.
Dividers:	A tab sheet keyed to the table of contents must separate each subsection of the proposal; the title of each subsection must appear on the tab sheet. Tabs should represent specific sections identified in the outline provided, example; A. should have a tab and F.1. as well.
Paper Size:	8½" x 11", "portrait" orientation
Print Style:	1-sided
Font Size:	Minimum of 11-point
Font Type:	Arial or Tahoma
Margins:	The binding edge margin of all pages shall be a minimum of one and one half inches (1½"); all other margins shall be one inch (1").
Line Spacing:	Single-spaced

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

10. **Packaging and Labeling Requirements.** All proposals must be submitted in sealed envelopes or packages and be addressed to the Official Contact. The Legal Name and Address of the Respondent must appear in the upper left corner of the envelope or package. The RFP Name must be clearly displayed on the envelope or package: **Person-Centered Medical Home Plus Program Wave 2 Request for Proposals**, **(PCMH+_W2_RFP)**. **PCMH+ W2 is acceptable**.

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

■ E. EVALUATION OF PROPOSALS

1. **Evaluation Process.** It is the intent of the Department to conduct a comprehensive, fair, and impartial evaluation of proposals received in response to this RFP. When evaluating proposals, negotiating with successful Respondents, and offering the right to negotiate a contract, the Department will conform with its written procedures for Purchase of Service (POS) procurements (pursuant to C.G.S. § 4-217) and the State's Code of Ethics (pursuant to C.G.S. §§ 1-84 and 1-85).

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

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

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

    1. Organization
    2. Enhanced Care Coordination Activities and Care Coordination Add-On Activities
    3. Quality
    4. Community and Clinical Integration Program
    5. Data and Reporting
    6. Subcontractor(s)
    7. Financial Requirements

5. **Respondent Selection.** Upon completing its evaluation of proposals, the Evaluation Team will submit the rankings of all proposals to the Department head. The final selection of a successful Respondent is at the discretion of the Department head. Any Respondent selected will be so notified and offered an opportunity to negotiate a contract with the Department. Such negotiations may, but will not automatically, result in

a contract. Any resulting contract will be posted on the State Contracting Portal. All unsuccessful Respondents will be notified by email or U.S. mail, at the Department's discretion, about the outcome of the evaluation and Respondent selection process.

6. **Debriefing.** After receiving notification from the Department, any Respondent may contact the Official Contact and request a Debriefing of the procurement process and its proposal. If Respondents still have questions after receiving this information, they may contact the Official Contact and request a meeting with the Department to discuss the procurement process. The Department shall schedule and conduct Debriefing meetings that have been properly requested, within fifteen (15) days of the Department's receipt of a request. The Debriefing meeting must not include or allow any comparisons of any proposals with other proposals, nor should the identity of the evaluators be released. The Debriefing process shall not be used to change, alter, or modify the outcome of a competitive procurement. More detailed information about requesting a Debriefing may be obtained from the Official Contact.

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

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

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

II. MANDATORY PROVISIONS

■ A. STANDARD CONTRACT, PARTS I AND II

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

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

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

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

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

■ B. ASSURANCES

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

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

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

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

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

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

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

■ C. TERMS AND CONDITIONS

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

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

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

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

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

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

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

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

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

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

■ D. RIGHTS RESERVED TO THE STATE

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

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

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

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

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

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

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

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

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

■ E. STATUTORY AND REGULATORY COMPLIANCE

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

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

2. **Contract Compliance, C.G.S. § 4a-60 and Regulations of CT State Agencies § 46a-68j-21 thru 43, inclusive.** CT statute and regulations impose certain obligations on State agencies (as well as Contractors and subcontractors doing business with the State) to ensure that State agencies do not enter into contracts with organizations or businesses that discriminate against protected class persons. Detailed information is available on CHRO's web site at Contract Compliance IMPORTANT NOTE: **The Respondent shall upload** the Workplace Analysis Affirmative Action Report through an automated system hosted by the Department of Administrative Services (DAS)/Procurement Division, and the Department of Social Services can review said document online. Create a BizNet account for Doing Business with the State

BizNet is a central database and online informational tool for companies looking to do business with the State of Connecticut.

3. **Consulting Agreements, C.G.S. § 4a-81.** Proposals for State contracts with a value of $50,000 or more in a calendar or fiscal year, excluding leases and licensing agreements of any value, shall require a consulting agreement affidavit attesting to whether any consulting agreement has been entered into in connection with the proposal. As used herein "consulting agreement" means any written or oral agreement to retain the services, for a fee, of a consultant for the purposes of (A) providing counsel to a Contractor, vendor, consultant or other entity seeking to conduct, or conducting, business with the State, (B) contacting, whether in writing or orally, any executive, judicial, or administrative office of the State, including any Department, institution, bureau, board, commission, authority, official or employee for the purpose of solicitation, dispute resolution, introduction, requests for information or (C) any other similar activity related to such contract. Consulting agreement does not include any agreements entered into with a consultant who is registered under the provisions of C.G.S. Chapter 10 as of the date such affidavit is submitted in accordance with the provisions of C.G.S. § 4a-81. The Consulting Agreement Affidavit (OPM Ethics Form 5) is available on OPM's website at http://www.ct.gov/opm/cwp/view.asp?a=2982&q=386038&opmNav_GID=1806

   IMPORTANT NOTE: **The Respondent shall upload** the Consulting Agreement Affidavit (OPM Ethics Form 5) through an automated system hosted by the Department of Administrative Services (DAS)/Procurement Division, and the Department of Social Services can review said document online. Create a BizNet account for Doing Business with the State is provided as a hyperlink.
   BizNet is a central database and online informational tool for companies looking to do business with the State of Connecticut.

4. **Limitation on Use of Appropriated Funds to Influence Certain Federal Contracting and Financial Transactions, 31 USC § 1352. The Respondent shall upload** a Certification Regarding Lobbying form that is available in the following hyperlink. http://www.ct.gov/opm/cwp/view.asp?a=2982&q=386038&opmNav_GID=1806 attesting to the fact that none of the funds appropriated by any Act may be expended by the recipient of a Federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the: (A) awarding of any Federal contract; (B) making of any Federal grant; (C) making of any Federal loan; (D) entering into of any cooperative agreement; or (E) extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

5. **Gift and Campaign Contributions, C.G.S. §§ 4-250 and 4-252(c); Governor M. Jodi Rell's Executive Orders No. 1, Para. 8 and No. 7C, Para. 10; C.G.S. § 9-612(g)(2).** If a Respondent is offered an opportunity to negotiate a contract with an anticipated value of $50,000 or more in a calendar or fiscal year, the Respondent shall fully disclose any gifts or lawful contributions made to campaigns of candidates for statewide public office or the General Assembly. Municipalities and CT State agencies are exempt from this requirement. The gift and campaign contributions certification (OPM Ethics Form 1) is available in the following hyperlink.
   http://www.ct.gov/opm/cwp/view.asp?a=2982&q=386038&opmNav_GID=1806

IMPORTANT NOTE: The selected Respondent shall upload the Gift and Campaign Contributions Certification (OPM Ethics Form 1) through an automated system hosted by the Department of Administrative Services (DAS)/Procurement Division prior to contract execution, and the Department of Social Services can review said document online. Create a BizNet account for Doing Business with the State is provided as a hyperlink. BizNet is a central database and online informational tool for companies looking to do business with the State of Connecticut.

6. **Nondiscrimination Certification, C.G.S. §§ 4a-60(a)(1) and 4a-60a(a)(1).** If a Respondent is offered an opportunity to negotiate a contract, the Respondent shall provide the Department with written representation or documentation that certifies the Respondent complies with the State's nondiscrimination agreements and warranties. A nondiscrimination certification is required for all State contracts – regardless of type, term, cost, or value. Municipalities and CT State agencies are exempt from this requirement. The nondiscrimination certification forms are available in the following hyperlink: http://www.ct.gov/opm/cwp/view.asp?a=2982&q=386038&opmNav_GID=1806

   IMPORTANT NOTE: The selected Respondent shall upload the Nondiscrimination Certification through an automated system hosted by the Department of Administrative Services (DAS)/Procurement Division prior to contract execution, and the Department of Social Services can review said document online. Create a BizNet account for Doing Business with the State is provided as a hyperlink. BizNet is a central database and online informational tool for companies looking to do business with the State of Connecticut.

7. **Form 7. Iran Certification**

   Rev. 3/28/14 Adobe.pdf Word.doc

   Effective October 1, 2013, this form must be submitted for any large state contract, as defined in section 4-250 of the Connecticut General Statutes. This form must always be submitted with the bid or proposal, or if there was no bid process, with the resulting contract, regardless of where the principal place of business is located. Entities whose principal place of business is located outside of the United States are required to complete the entire form, including the certification portion of the form. United States subsidiaries of foreign corporations are exempt from having to complete the certification portion of the form. Those entities whose principal place of business is located inside of the United States must also fill out the form, but do not have to complete the certification portion of the form.

III. PROGRAM INFORMATION

■ A. DEPARTMENT OVERVIEW

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

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

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

2. **Department Vision**
   To become a world-class service organization.

■ B. MEDICAID PROGRAM OVERVIEW

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

■ C. STATE INNOVATION MODEL (SIM) OVERVIEW

The State Innovation Model (SIM) is a Center for Medicare & Medicaid Innovation (CMMI) initiative to support the development and implementation of multi-payer healthcare payment and service delivery model reforms that will lead to better care, smarter spending, and healthier people and communities. Connecticut received a $45 million model test grant from CMMI that is supporting a number practice transformation and value-based payment projects, including PCMH+.

The SIM is led by a Project Management Office (PMO) that is currently located within the Office of the Healthcare Advocate and serves under the leadership of the Lieutenant Governor.

■ D. PCMH+ OVERVIEW

An overview of PCMH+ is described in SECTION I. GENERAL INFORMATION. A. INTRODUCTION. 2. Summary.

NOTEWORTHY:

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

Under PCMH+, the Department will contract with qualified provider organizations to be PCMH+ Participating Entities for a contract period beginning **April 1, 2018 and ending December 31, 2019.**

■ E. INTENSIVE CARE MANAGEMENT (ICM)

The PCMH+ PEs will have oversight of care coordination for members in their practice, including those individuals who had been participating in an ASO's ICM program. Members who opt out of the PCMH+ care coordination service will remain eligible for services through the ASO ICM program. Members with extensive, in-depth care needs (e.g. high-risk pregnancy, sick-cell disease) may stay with ASO ICM services and not transition to the PCMH+ practice; a process that will include communication between the ASO and the PE with regard to these members.

For members currently enrolled in an ASO's ICM program, but assigned to a PCMH+ practice, both ASO and the PCMH+ practice will work in collaboration to transition members from ASO's ICM program to the PCMH+ PE for PCMH+ care coordination. All members assigned to a participating PCMH+ PE are eligible for PCMH+ care coordination interventions and PCMH+ providers are expected to provide outreach to all such assigned members to identify care coordination and social determinants of health needs. PCMH+ underscores the Department's commitment to support PEs in effectively serving their communities by offering all available supports to PCMH+ assigned members, including care coordination and linkages to community supports.

PCMH+ assigned members can elect to remain enrolled with the ASO ICM program, or transition to the PCMH+ practice. If a member wishes to stay with the ASO ICM program, then the ASO should notify the PCMH+ practice of the member's preference. To the extent possible, the ASO and the PCMH+ practice shall collaborate on care coordination actions to avoid duplicating resources and efforts. For new members entering into an ASO ICM, but attributed to a PCMH+ practice, the ASO ICM will notify the PCMH+ Care Coordinator to facilitate transition of the member to PCMH+ care coordination supports.

■ F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS

PCMH+ W 2 will build on DSS' existing PCMH and PCMH+ W 1 program by focusing upon Enhanced Care Coordination Activities and Care Coordination Add-On Activities related to the integration of primary care and behavioral health care, building on provider competencies to support Medicaid members with complex medical conditions and disability needs, and promoting linkages to community supports that can assist members in utilizing their Medicaid benefits. PCMH+ PEs will provide care coordination activities in addition to the care coordination that is already required for participation in the DSS PCMH program. Under PCMH+, PEs will provide Enhanced Care Coordination Activities to improve the

quality, efficiency, and effectiveness of care. All PCMH+ PEs (both FQHCs and Advanced Networks) that meet identified benchmarks on quality performance standards and under-service prevention requirements will be eligible to participate in shared savings. DSS will also make an additional Care Coordination Add-On Payment to PCMH+ PEs that are FQHCs to support Care Coordination Add-On Payment Activities as outlined below.

The PCMH+ PE must provide required care coordination through individuals employed by or under contract to the PCMH+ PE. Regardless of the specific method of providing care coordination, the PCMH+ PE must ensure that care coordination is an essential part of the services provided by the PCMH+ PE and is fully integrated into the day-to-day work of the overall entity.

PCMH+ PEs must evaluate and utilize the results of provider profile reports provided by the Medicaid program's medical ASO (Community Health Network Connecticut (CHNCT)), to the extent available, to improve quality of care. Provider profile reports will analyze measures of health care and clinical quality measure results from Connecticut PCMH+ providers. The report provides quantitative provider feedback at the statewide, practice setting and individual provider/practice level that can be used to direct resources and inform policy. A defined set of health quality measures are used to compare regular provider results from the following sources: Healthcare Effectiveness Data and Information Set (HEDIS), Children Health Insurance Program Reauthorization Act (CHIPRA), Custom measures specified by the Department, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The reports are used to give providers feedback on their performance in comparison to other providers of the same type and specialty.

1. **Eligible Population**

   All Connecticut Medicaid members except those described below are eligible for PCMH+:

   a. Behavioral Health Home (BHH) participants.
   b. Partial Medicaid/Medicare dual eligible members; individuals participating in a Medicare Accountable Care Organization (ACO); and individuals enrolled in a Medicare Advantage plan.
   c. Home and community-based services participants served under section 1915(c) waiver, section 1915(i), and section 1915(k).
   d. Money Follows the Person (MFP) participants.
   e. Residents of nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) and other long-term care institutions that are required to coordinate care for their residents.
   f. Individuals enrolled in a limited benefit package (current limited benefits: family planning, breast and cervical cancer, and tuberculosis).
   g. Individuals receiving hospice services.

   These members will not be assigned to PCMH+ since they have another source of health care coverage, a limited Medicaid benefit, or receive care coordination through other programs.

2. **Organizational Requirements of PCMH+ Participating Entities**

   To be eligible to participate in the PCMH+ W2 RFP, Respondents must meet the minimum requirements for all PCMH+ Participating Entities plus the criteria for either a FQHC or an Advanced Network, as applicable to the Respondent. **These minimum submission qualification requirements are listed in**

SECTION I.GENERAL INFORMATION:

Executive Summary

D. PROPOSAL FORMAT 7. Minimum Submission Qualification Requirements, and are required of the Respondent to submit a proposal, AND

E. EVALUATION OF PROPOSALS 3. Minimum Submission Qualification Requirements

The Department will only enter into contracts under PCMH+ with FQHCs and Advanced Network Lead Entities (on behalf of Advanced Networks) that meet minimum requirements. PCMH+ Participating Entities may have common or diverse ownership (i.e., the PCMH+ Participating Entity may be comprised of one or multiple provider organizations, whether or not these organizations are part of one common system or ownership).

In addition to the minimum requirements listed in SECTION I.GENERAL INFORMATION D. PROPOSAL FORMAT 7. Minimum Submission Qualification Requirements each PCMH+ Participating Entity must also meet or provide the following requirements:

a. Participating Entities must provide assistance to PCMH+ Members to enable them to attend oversight body meetings (including such assistance as transportation and childcare).

b. PCMH+ PE must circulate relevant written reports and materials in advance to the members of the oversight body.

c. Have formal procedures through which to receive feedback from the oversight body and documentation of this communication must be made available to DSS upon request.

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

e. Enter into a contract with DSS.

f. Identify a clinical director and a senior leader to represent the Participating Entity and champion PCMH+ goals. These positions are not required to be full time or solely dedicated to PCMH+. The appointment and removal of the clinical director and senior leader must be under the control of the oversight body.

g. Receive any shared savings achieved and distribute the shared savings to participating providers within the Participating Entity, using a written distribution methodology that is subject to review and approval by the Department. This requirement is to minimize any potential incentives for individual practitioners to cause or promote under-service. This includes removing any direct incentive that might potentially encourage a practitioner to avoid referring a patient for medically necessary tests or procedures that would potentially increase expenditures substantially. With the exception of that exclusion, PCMH+ Participating Entities will have a substantial amount of discretion and flexibility in designing their distribution

methodology for shared savings payments. Non-DSS PCMH primary care practices within a Participating Entity may not receive a portion of any shared savings achieved by the entity.

h. Not distribute shared savings payments, if any, to any individual physician, APRN or physician assistant within the participating entity using any factors that would reward such individual for that individual's specific contributions to the overall savings generated by the participating entity.

i. Not engage in any activities designed to result in selective recruitment and attribution of individuals with selective recruitment and attribution of individuals with the intent of improving the probability of achieving savings and demonstrate compliance with under-service prevention requirements.

1) In addition to complying with all requirements that apply to all PCMH+ PEs and the Minimum Submission Qualification Requirements referenced above, **Advanced Network** must also:

a) Include one or more practice(s) that is/are currently participating in the DSS PCMH program as a PCMH and hold/holds appropriate level Patient-Centered Medical Home recognition from NCQA. Practices with Glide Path designation, which is a step towards DSS PCMH recognition, do not count as meeting this requirement. Each PCMH practice may participate in only one Advanced Network and cannot change during a Performance Year.

b) An Advanced Network can only receive shared savings payments based on PCMH+ eligible members who are attributed to a DSS PCMH practice within the network. Distribute shared savings to Advanced Network participating providers, using a written distribution methodology that is subject to review and approval by the Department. PCMH+ Participating Entities have discretion and flexibility in designing their distribution methodology for shared savings payments. For example, a network could choose to distribute shared savings payments based on a practitioner's quality of performance, patient satisfaction, and/or other metrics. These factors should be captured in each Respondent's description of its proposed shared savings methodology.

c) Advanced Networks are encouraged to include additional providers, and will be required in the response to this RFP to include signed letters of intent for each provider included in the Advanced Network. Acceptable options for Advanced Network composition include:

(1) One or more DSS PCMH practice(s);
(2) One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health, and oral health providers;
(3) One or more DSS PCMH practice(s) plus specialist(s) (which could include physical health, behavioral health and oral health providers) and one or more hospital(s); or
(4) A Medicare ACO that includes one or more DSS PCMH practice(s).

d) Designate an Advanced Network Lead Entity that is a provider or provider organization participating in the Advanced Network. If the Advanced Network is comprised of more than one provider organization, have a

contractual relationship with all other Advanced Network participating providers for the purposes of PCMH+. The contract must at a minimum contain:

(1) An explicit requirement that each Advanced Network participating provider agrees to participate in and comply with the applicable requirements of the PCMH+;
(2) A description of the Advanced Network participating provider's rights and obligations in, and representation by, the Advanced Network Lead Entity, including language giving the Advanced Network Lead Entity the authority to terminate a provider's participation in the Advanced Network for its non-compliance with the Advanced Network participation agreement or any of the requirements of Connecticut Medicaid;
(3) Language that Advanced Network participating providers must allow PCMH+ Members freedom of choice of provider and

Please Note:

i. An Advanced Network can alter its composition of participating health care entities and/or community partnerships at any time, so long as the Advanced Network continues to meet all PCMH+ requirements. The Advanced Network must promptly inform DSS in writing of any such changes and update appropriate documentation accordingly.

ii. A health care participant in a network is not obliged to remain with the network through the end of the calendar year and can leave at any time. However, the departure of a PCMH from an Advanced Network will result in removal of its assigned members for purposes of calculating any applicable shared savings payment.

iii. A range of non-primary care provider types can participate in the Advanced Network, such as specialist(s) and/or hospital(s) or a Medicare Accountable Care Organization (ACO). Those non-primary care provider entities are not be eligible to participate in the DSS PCMH program but may participate as part of the Advanced Network.

iv. The Advanced Network can choose how to characterize itself and could potentially include a subset of a health system, rather than the entire health system, so long as the Advanced Network can clearly describe and document how it is comprised and structured. A health system also clearly has a substantial amount of flexibility in how it is structured including which providers are included within which entities.

v. DSS understands that Advanced Networks may have a variety of arrangements with emergency physicians, on-call services, and other practitioners. Many of these physicians may not be part of the PCMH+ Advanced Network but could provide services to the beneficiary without the Advanced Network violating PCMH+ requirements. However, the Network is encouraged to require all physicians who provide services to Medicaid patients to enroll as Medicaid providers for other reasons, including in order to comply with federal law at 42 U.S.C. § 1396a(kk)(7), which requires any order/referral/prescription for Medicaid goods/services to be issued by a physician or other applicable licensed practitioner who must be individually enrolled in Medicaid.

3. Retrospective Attribution and Prospective Assignment Methodology

Eligible Medicaid members as described in SECTION III. PROGRAM INFORMATION

F.PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 1. Eligible Population will be assigned to PCMH+ PEs using DSS' existing retrospective attribution methodology that is used for primary care providers in Connecticut's Medicaid program and for the PCMH program), adapted, as necessary, for PCMH+. The PCMH retrospective attribution methodology attributes a Medicaid beneficiary to a PCMH based on the beneficiary's active choice of provider (i.e., usual source of care). Even if the PCMH+ PE includes other providers, only the members assigned to a PCMH will be considered to be PCMH+ Participating Entity's members. Eligible Medicaid members will be assigned to only one PCMH+ PE. Medicaid members will be assigned to PCMH+ PEs for each contract period in advance, based on attribution of these individuals to PCMH practices using the Medicaid attribution methodology. PEs must identify each site location participating in PCMH+, and associated Tax Identification Number (TIN) to that specific site location. Eligible Medicaid members will be assigned to a PCMH+ PE within the first quarter of 2018 for Wave 2 starting April 1, 2018.

Please note that the Department is currently in the process of considering one or more changes to the attribution methodology to improve accuracy. As part of implementing those changes, PEs may be required to provide additional information and/or provide additional details on billing claims. The Department will provide additional information as it becomes available.

PCMH+ Members retain the right to choose to see any qualified Medicaid provider. Members will be notified of this right through an established notification process. PCMH+ Members will continue to be eligible for all services covered by the Connecticut Medicaid program, including those not included in the shared savings calculation.

Eligible Medicaid members will have the ability to opt-out of assignment to PCMH+ at any time. If an eligible Medicaid beneficiary opts-out of PCMH+, then that members' claim costs will be removed from the assigned PCMH+ PE's shared savings calculation and quality measurement. If an eligible Medicaid beneficiary opts-out of the PCMH+ and that beneficiary's assigned PCMH+ PE was an FQHC, then that FQHC will no longer receive the Care Coordination Add-On Payment for that beneficiary.

In order to be included in shared savings, full PCMH certification must be obtained before the Department runs the attribution list that will be used to assign members for the performance year. If a PCMH is not certified at the start of the PCMH+ performance year, but achieves certification during that year, members attributed to that practice are not counted as part of PCMH+ shared savings. However, if practice becomes certified as a PCMH before the attribution is performed that results in the assignment of PCMH+ members for the following performance year, then so long as the Advanced Network met all applicable RFP requirements, those individuals will be counted as part of the PCMH+ shared savings for the following program year.

The Department strongly recommends that all PCMH+ PEs focus on providing high quality, person-centered service to members. Members may be more likely to choose to remain with the PCMH+ PE if there is high quality customer service and clinical practices. The Department also recommends that PCMH+ Participating Entities make reasonable efforts to assist their members in maintaining continuous eligibility for Medicaid (as long as such individuals continue to comply with applicable eligibility requirements).

4. Enhanced Care Coordination Activities

PCMH+ PEs will provide Enhanced Care Coordination Activities to PCMH+ Members.

All PCMH+ Members are eligible and should receive enhanced care coordination. Respondents should detail in their responses what efforts that will be made to outreach to and engage members in care coordination. The Enhanced Care Coordination Activities that the Department has selected for PCMH+ leverage national best practices in care coordination and exceed the FQHC, HRSA, and Patient-Centered Medical Home recognition requirements as defined by NCQA or ambulatory care entities with a Primary Care Medical Home certification from The Joint Commission. Respondents should demonstrate that the time that is allocated to care coordination activities is sufficient to support Medicaid members, including, but not limited to, time allocated to the required behavioral health integration activities. Respondents must outline how this staff will be hired or contracted for, and what, if any, other responsibilities the staff or contractors will have within the Respondent's organization.

All PCMH+ PEs must perform the required Enhanced Care Coordination Activities. PCMH+ Participating Entities that are FQHCs will provide both the Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities, which will be reimbursed through the Care Coordination Add-On Payment.

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

a. Behavioral Health/Physical Health Integration
   i. Employ a care coordinator with behavioral health education, training, and/or experience who participates as a member of the interdisciplinary team.
   ii. Use standardized tools to expand behavioral health screenings beyond depression. PCMH+ focuses on PCMH medical primary care settings. Accordingly, it is the expectation that screening tools will be administered in the medical primary care setting. Participating Entities are encouraged to implement screening tools in both medical and behavioral health settings as broader screening improves identification of at-risk members.
   iii. Promote universal screening for behavioral health conditions across all populations, not just those traditionally identified as high risk.
   iv. Obtain and maintain a copy of a member's psychiatric advance directive in the member's file.
   v. Obtain and maintain a copy of a member's Wellness Recovery Action Plan (WRAP) in the member's file. WRAP is a federal Substance Abuse and Mental Health Services Administration (SAMHSA) evidenced-based practice and is used both nationally and within Connecticut's behavioral health system. However, providers may utilize alternative behavioral health recovery planning tools that meet similar objectives to WRAP. These tools should help patients develop an individualized plan with a focus on meeting individualized recovery goals. DSS will not require the use of a specific recovery planning tool. In their responses, Respondents should describe the tools they plan to use to meet this requirement, including how they plan to ensure appropriate documentation that it has been met, and how the tools support individualized recovery planning.

b. Culturally Competent Services
   i. Require annual cultural competency training for all practice staff. Cultural competency training will include the needs of individuals with disabilities.
   ii. Expand any individual care plan currently in use to include an assessment of the impact culture has on health outcomes.
   iii. Require compliance with culturally and linguistically appropriate services (CLAS) standards as defined by the U.S. Department of Health and Human Services,

Office of Minority Health (see Attachment B for the CLAS standards).

c. Care Coordinator Staff Requirements
The PCMH+ Participating Entity must provide required care coordination through individuals directly employed by, under contract to, or otherwise affiliated with the PCMH+ Participating Entity. The PCMH+ Participating Entity will be required to define minimum care coordinator education and experience requirements and determine if leveraging non-licensed staff such as community health workers is desired. Requirements include:
   i. Employ a full time care coordinator dedicated solely to care coordination activities.
   ii. Assign care coordination activities to multiple staff within a practice.
   iii. Contract with an external agency to work with the practice to provide care coordination.

d. Children and Youth with Special Healthcare Needs (CYSHCN): Age 0-17 Years
The Maternal Child and Health Bureau define CYSHCN as: "Those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." This definition is broad and inclusive, and it emphasizes the characteristics held in common by children with a wide range of diagnoses. Examples include children with diagnoses such as diabetes or asthma that is not well controlled.

   i. Require advance care planning discussions for CYSHCN. Advance care planning is not limited to CYSHCN with terminal diagnoses. It can occur with CYSHCN with chronic health conditions, including behavioral health conditions, that significantly impact the quality of life of the child/youth and his/her family.
   ii. Develop advance directives for CYSHCN.
   iii. Include school-related information in the member's health assessment and health record, such as: The individualized education plan or 504 plan, special accommodations, assessment of patient/family need for advocacy from the provider to ensure the child's health needs are met in the school environment, how the child is doing in school and how many days have been missed due to the child's health condition, and documenting the school name and primary contact.

e. Competencies in Care of Individuals with Disabilities (inclusive of physical, intellectual, developmental and behavioral health needs)
   i. Expand the health assessment to include questions about: durable medical equipment (DME) and DME vendor preferences, home health medical supplies and home health vendor preferences, home and vehicle modifications, prevention of wounds for individuals at risk for wounds, and special physical and communication accommodations needed during medical visits.
   ii. Adjust appointment times for individuals who require additional time to address physical accommodations, communication needs, and other unique needs for individuals with disabilities. Individuals may be seen by the primary care physician and other members of the interdisciplinary team during these adjusted appointment times.
   iii. Develop and require mandatory disability competency trainings to address the care of individuals with physical and intellectual

disabilities.

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

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

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

5. Care Coordination Add-On Activities

The following Care Coordination Add-On Payment Activities will be required of FQHC PCMH+ PEs.

a. Behavioral Health/Physical Health Integration - Employ a care coordinator with behavioral health experience who serves as a member of the interdisciplinary team and has the responsibility for tracking patients, reporting adverse symptoms to the team, providing patient education, supporting treatment adherence, taking action when non-adherence occurs or symptoms worsen, delivering psychosocial interventions, and making referrals to behavioral health services outside of the FQHC as needed.

b. Develop WRAPs or other behavioral health recovery planning tools in collaboration with the patient and family.

c. Transition-Age Youth (TAY). Expand the development and implementation of the care plan for TAY with behavioral health challenges (e.g., collaborative activities to achieve success in transition and/or referrals to and coordination with programs specializing in the care of TAY with behavioral health challenges). TAY is defined as "individuals between the ages of 16 and 25 years. The age range for transition age youth (TAY) can vary to include children as young as 12 years of age." Depending on the needs of the youth served, providers may choose to expand the upper and lower age range for TAY. In their responses, Respondents should include information regarding the profile of TAY that is managed by the Respondent.

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

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

6. Quality Strategy and Quality Measure Set

The Department's PCMH+ goals are to improve quality and the care experience of Medicaid members. The PCMH+ quality strategy, including a quality measure set and

compliance with under-service prevention requirements will be used to evaluate PCMH+ PEs' performance and overall program success. The PCMH+ PE's ability to receive shared savings will be contingent on its quality score. For more information regarding the PCMH+ shared savings payment methodology, please refer to SECTION III. PROGRAM INFORMATION.F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 7. Overview of Payment Methodology.

The current version of the PCMH+ quality measure set can be found in **Attachment A** of this RFP. Data for the majority of quality measures, including Healthcare Effectiveness Data and Information Set (HEDIS) measures, will be collected from PCMH+ Member claims and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Hybrid HEDIS measures (those measures that can be collected using both administrative data and medical record abstraction) will only be evaluated using administrative data at this time, although in the future the Department could move towards medical record abstraction. Quality measures used to determine shared savings payments in the Performance Year will be limited to these claims-based measures.

PCMH+ PEs will only receive a shared savings payment if they meet identified benchmarks on quality performance standards and under-service prevention requirements. Providers will be disqualified from receiving shared savings if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality.

7. Overview of Payment Methodology

PCMH+ includes two categories of payment: Shared savings payments (individual pool payments and challenge pool payments) and prospective care coordination add-on payments. Care Coordination Add-On Payments are only available to PCMH+ PEs that are FQHCs.

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

a. Care Coordination Add-On Payment Methodology

DSS will make Care Coordination Add-On Payments prospectively on a monthly basis to PCMH+ PEs that are FQHCs. These payments will provide financial support to help FQHCs make the necessary investments to provide Care Coordination Add-On Payment Activities. Care Coordination Add-On Payments are appropriation-limited; the amount of the payment will depend on the number of PCMH+ PEs and the size of their attributed PCMH+ membership.

Care Coordination Add-On Payment Activities are in addition to care coordination activities required under HRSA standards for FQHCs, under criteria for Patient-Centered Medical Home recognition from NCQA or Primary Care Medical Home certification from The Joint Commission for any participating entities, and by an FQHC's participation in the DSS PCMH program. The Care Coordination Add-On Payment Activities are also in addition to the Enhanced Care Coordination Activities required of all PCMH+ PEs.

i. The monthly attributed PCMH+ membership may change from month to month. Members may choose to opt out of the program, may fall into a PCMH+ excluded category, or lose HUSKY eligibility. The Care Coordination Add-On Payments will only be made for members who are attributed in the

month where the payment is made. Members who are reinstated to HUSKY eligibility and retroactively have continuous enrollment will trigger a retroactive payment for the months where the add-on payment was not made, but only for those members who were retroactively reinstated no later than 120 days after they temporarily lost coverage. Members who return to HUSKY eligibility after a period of being ineligible (*i.e.*, were not retroactively reinstated for continuous enrollment) will not receive care coordination and the FQHC will not receive the care coordination add-on payment during the period of ineligibility. After the member returns as fully eligible, the care coordination and care coordination add-on payment will continue. Only members who had at least 11 months of eligibility (includes retroactive eligibility) in a calendar year will be included in the shared savings calculation for a Performance Year that aligns with that calendar year.

There is a limited pool of money for the care coordination add-on payment, but once the funds are exhausted there will be no more add-on payments.

b. Shared Savings Payment Methodology

Shared savings payments will be made to PCMH+ PEs that meet specified requirements for quality measures (including measures of under-service) and measures of savings. Because it is not yet known how much, if any, savings will be achieved under PCMH+, it is also not possible to predict how much funding may be available. Shared savings payments, if applicable, would be made on or about several months after the close of the PCMH+ program year (roughly in late 2019 for program year 2018). The shared savings payment methodology will adhere to the following guiding principles:

- Only PCMH+ PEs that meet identified benchmarks on quality standards and under-service prevention requirements will be eligible to participate in shared savings.
- PCMH+ PEs will be disqualified from receiving shared savings if any of their providers is found to be underserving or manipulating their panel.
- Maintaining and improving quality will factor into the calculation of shared savings.
- Higher quality scores will allow a PCMH+ PE to receive more shared savings.
- PCMH+ PEs that demonstrate losses (i.e., increased expenditures incurred by Connecticut Medicaid) will not be required to share in losses. This means that they will not be required to return any portion of such increased expenditures to the Department.
- PCMH+ PEs will be compared to a series of targets or benchmarks for quality and cost.

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

c. Benefits Included in the Shared Savings Calculation

The PCMH+ PE’s shared savings calculation includes the cost of a defined set of

benefits that is the same for all PCMH+ PEs. PCMH+ PEs do not need to deliver all benefits; rather, the cost of these benefits will be included in the PCMH+ PE's shared savings calculation. PCMH+ PEs may impact the cost of these benefits through the provision of Enhanced Care Coordination Activities and addressing social determinants of health through implementing linkages to community partners.

All Medicaid claim costs for covered benefits will be included in the shared savings calculation for the PCMH+ PE, with the exception of Hospice; Long-term services and supports, including institutional and community-based services; other waiver services; and Non-emergency medical transportation. PCMH+ Members will continue to be eligible for all benefits covered by the Connecticut Medicaid program, including those listed above that are excluded from the shared savings calculation, and will retain free choice of all qualified Medicaid providers.

I. Individual Savings Pool

A PCMH+ PE's Individual Savings Pool will be funded by the savings generated by each PCMH+ PE. The PCMH+ PE's shared savings payment in the individual pool will be determined by the PCMH+ PE's total quality score. The total score will be developed based on the PCMH+ PE's performance on three components of quality measurement (maintain quality, improve quality, and absolute quality) for each of the quality measures, the current version of which is listed in **Attachment A**.

The PE's shared savings payment in the Individual Savings Pool will be determined in part by the PE's total quality score. A PE's total quality score will be based on three components of quality measurement (maintain quality. improve quality. and absolute quality) for each of the quality measures. A maximum of one point is available for each component of quality measurement for each measure. The three components of quality measurement in the individual savings pool are:

1. Maintain Quality: One point is awarded if a PE's Performance Year quality score is greater than or equal to its Prior Year score. (An adjustment may be made to account for unexpected annual variation which results in lower scores).

2. Improve Quality: A PE will earn points in accordance with the sliding scale included below based on its year-over-year performance (quality improvement performance) against the quality improvement trend derived from all Participating Entities.

Quality Improvement Measured as a Percentile	**Points Awarded**
49.99% or less	0.00
Between 50.00% and 59.99%	0.25
Between 60.00% and 69.99%	0.50
Between 70.00% and 79.99%	0.75
80.00% or greater	1.00

3. Absolute Quality: A PE will earn points in accordance with the sliding scale included below for its ability to reach absolute quality targets, derived from a comparison group's quality scores.

Quality Performance Measured as a Percentile	Points Awarded
Between 0 and 49.99%	0.00
Between 50% and 59.99%	0.25
Between 60% and 69.99%	0.50
Between 70% and 79.99%	0.75
Between 80% or greater	1.00

4. To calculate each PE's total quality score its points will be summed and then divided by a maxim um score of 27 points (three possible points per quality measure with nine total quality measures). The total quality score, expressed as a percent will be used in calculating the portion of a PE's Individual Savings Pool that will be returned to the PE as shared savings.

   A PCMH+ PE will receive its savings from the individual savings pool in accordance with the model described below:

   - Each PE Individual Savings Pool will be funded by savings it generated during the Performance Period.
   - The calculated savings will be subject to a minimum savings rate (MSR) limited by a savings cap, and multiplied by a sharing factor to generate the available Individual Savings Pool shared savings payment amounts, if any.
   - For each PE, the calculation of savings will be based on the extent to which the PE achieved a lower cost trend than a comparative cost trend to be derived from non-participating entities.
   - Savings will only be calculated based on PCMH+ members who remain assigned and maintain at least 11-months of Medicaid Eligibility for the Performance Year. Cost data of members who opt out of PCMH+ will not be used in the calculation of shared savings. In addition, to avoid unwanted bias due to outlier cases, for each PCMH+ member, annual claims will be truncated at $100,000, so that expenses above $100,000 will not be included in the calculation.
   - Risk adjustment methods will be used to adjust both Prior Year and Performance Year costs for underlying differences in illness burden.
   - A PE's Risk Adjusted Expected Performance Year costs will be developed by multiplying the Entity's Risk Adjusted Prior Year Cost by the comparative cost trend. A PE's savings will be the difference between its Risk Adjusted Expected Performance Year costs and its actual Risk Adjusted Performance Year costs. PEs that demonstrate losses (i.e. higher than expected expenditures for members assigned to the PE) will not return these losses.
   - Minimum Savings Rate: A PE's risk-adjusted savings must meet the MSR requirement, which is greater than or equal to 2% of the expected Performance Year Costs. If a PE meets the MSR requirement, then the first-dollar savings (i.e., all savings generated. including amounts below

the MSR threshold) will be considered as savings. If a PE does not meet the MSR requirement, its savings will not be considered. Likewise, losses between 0% and -2% will not be considered credible when deriving the aggregate program savings.

- Savings Cap: PE's savings will be capped at 10% of Risk Adjusted Expected Performance Year Costs, so that any savings above 10% will not be included in its Individual Savings Pool.
- Sharing Factor: If a PE has savings above, savings will be multiplied by a Sharing Factor of 50%. The resulting amount will form the PE's Individual Savings Pool.

II. Challenge Pool

It is expected that one or more PE may not receive 100% of their individual Savings Pool as shared savings payments because of less than perfect scores on the quality measures or because DSS determined that the PE systematically engaged in under-service for Medicaid members. The amounts not returned will be aggregated to form a target amount for the Challenge Pool. The Challenge Pool funding is limited to ensure that the Challenge Pool payments will not exceed the Aggregate Savings of the PCMH+ program less the Aggregate Individual Savings Pool payments. For this test, the Aggregate Savings of the PCMH+ program is defined as all credible savings and losses for all PEs (i.e., subject to the MSR requirement and subject to all other requirements for calculating available individual savings pool shared savings). Performance on a set of challenge measures, listed in Attachment A, will inform the challenge pool payment through the use of a member-weighted distribution by PCMH+ PE. For each quality measure, a PCMH+ PE must achieve at least the median score of all PCMH+ PEs that are participating in the challenge pool, for that measure to be counted within the member-weighted distribution. The quality measures used for the challenge pool are a separate set of quality measures than the nine quality measures used in the individual savings pool.

8. Monitoring and Reporting

PCMH+ practices must participate in the following Evaluation and Reporting Tools for Wave Two. The PCMH+ Evaluation and Reporting Tool requirements from Wave One, will be incorporated into Wave Two.

PCMH+ PEs will submit PE Compliance Reports. Reports are designed to be a high-level tracking method to ensure practices are meeting requirements of the PCMH+ contract. Reports will assist DSS in identifying areas of concern, and if needed, assist DSS in issuing corrective action plans. Reports will be submitted monthly for PEs new to the program. Reports will be submitted quarterly for PEs that participated in Wave 1. Reports will gather information on several contract requirement areas, including:

- Staff requirements and training sessions
- Performance of Enhanced Care Coordination activities
- Community Advisory Board activity
- Frequency of member contacts and general member demographic information
- Community partnerships to address social determinants of health (see section 10 below)
- Interdisciplinary team meeting activity

PCMH+ PEs that do not provide sufficient evidence of performing the required Enhanced Care Coordination Activities and Care Coordination Add-on Activities as determined by DSS, may be subject to a corrective action plan and may be ineligible to participate in shared savings.

PCMH+ PEs will host quarterly Oversight Body Meetings. The PCMH+ PE must circulate relevant written reports and materials in advance to the members of the oversight body. The PCMH+ PE must have formal procedures through which to receive feedback from the oversight body and documentation of this communication must be made available to DSS upon request.

PCMH+ PEs may send group communications to Medicaid members regarding PCMH+. PCMH+ PEs shall send DSS a copy of the intended communication for review and approval before sending communication to Medicaid members.

PCMH+ PEs may be asked to participate in offsite desk review and on-site compliance reviews conducted by the Department of the PCMH+ program. Materials for the offsite desk review will be requested from the PEs and will be reviewed for compliance with contract requirements. Sample documents may include policies and procedures, DSS PCMH+ reports and internal manuals. Onsite compliance reviews may assess compliance with RFP requirements, any areas noted for follow-up from the desk review or other reports submitted to the Department, best/promising practices, and areas in which there is potential for improvement. The onsite reviews may include interviews with PCMH+ members, participants of Community Advisory Bodies, and staff members to gauge their opinions of the program, and will include a chart review to evaluate quality and completeness of members' clinical records.

9. Year End Report

At the end of the performance year, the PE will submit a Year End Report within 90 days after the close of the year (December 31, 2018 and December 31, 2019). The Year End report will include the following, and any additional information the Participating Entity would like to include in the report that will assist the Department in review of the performance year:

- Look back of the performance year, identifying key areas of success, goals achieved, highlights of the performance year, project performance outcomes, and key milestones.
- Knowing that programs are never executed 100% successfully, identify areas that were not fully developed or areas of failure. Develop an analysis about why failure occurred, with improvement suggestions, change recommendations, and design change recommendations.
- Identify program challenges, and outline risk mitigation strategies used to respond to the challenge. Make recommendations and suggestions to the Department on areas of concern.
- Budget recap with final year cost report outlining how funds were spent including Care Coordination Add-On Payments, shared savings, and any other funds provided by the Department and/or other funds from other sources used for purposes of the program including gifts-in-kind.

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

In an effort to meaningfully impact the social determinants of health, promote physical and behavioral health integrated care, and assist members in utilizing their Medicaid benefits, PCMH+ PEs must implement and enhance contractual relationships or informal partnerships with local community partners. Community Partnerships will meaningfully impact social determinants of health, promote physical and behavioral health integrated care, and facilitate rapid access to care and needed resources.

PEs must sponsor local community collaborative forums or participate in existing

collaborative forums to develop broader understanding and partnerships between health providers and community resource agencies. PEs will be able to demonstrate the results of engaging in partnerships, available access for members to various types of medical and non-medical services, and observations regarding the potential short-term and long-term impacts on members. Examples of Community Partnerships may include:

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

11. Recommended Technical Criteria for eCQM and CCD Data

In support of SIM care delivery and payment reform goals, providers selected for participation must demonstrate a capacity and commitment to a number of fundamental technical requirements. Please attest to your current and/or planned capability for the following technical components as well as any issue that would prevent you from fulfilling the requirement:

1. Your practice must agree to enter into a Data Use and Reciprocal Support Agreement (DURSA). This is a legally enforceable contract between you and the Office of the Healthcare Advocate/SIM Project Management Office that allows for exchange of health information. The DURSA is necessary for the sharing of clinical data contained in your EHR for the purpose of performance and quality measurement by the SIM program.
2. Your practice must use an ONC-certified EHR system that allows for capture of data that will be used for quality measurement.
3. Your practice must commit to using your EHR system to consistently collect complete, accurate, structured clinical and demographic data. For example, if data fields used for quality measurement are left blank or important information is contained in free-form notes, the SIM program will not be able to collect data for analyses.
4. Your practice must commit to installing an edge-server by X date, so that the SIM program can index data in your EHR for quality measurement and reporting.
5. Your practice must have a system to collect and verify patient consent.
6. Your practice's providers must be listed in the state's Provider Directory.
7. Your practice must use a patient population risk stratification tool to identify complex patients requiring multi-disciplinary care team coordination.
8. Your practice must use a care management tool.
9. Your practice must use a system to send and receive Alerts to communicate across your care team.

Additionally, we would like to know a little more about your practice so that we can provide the needed technical assistance to assist in the successful implementation of

SIM goals. Describe your experience with electronic quality measurement and reporting.

a. Have you received technical assistance when implementing your EHR to optimize workflows to effectively use quality, prevention, and population health oriented functionality? Does your EHR have these functionalities?
b. How long have you used your current EHR?
c. Does your EHR have, and are you currently using, clinical decision support functionality?
d. Are you currently using automated quality reporting?
e. What quality measures are you currently tracking?
f. Have your workflows been adjusted to document diagnoses and preventive services in structured fields recognized for automated quality measurement? E.g. Are diagnostic orders, lab test results, and patient smoking status recorded in structured fields?
g. Do all the providers at your practice document diagnoses and preventive services in the same way and in the same place in your EHR?

12. Community and Clinical Integration Program (CCIP)

The SIM-funded Community and Clinical Integration Program (CCIP) establishes care delivery standards and provides technical assistance (TA) to support PCMH+ PEs in meeting the CCIP standards and improve the way they deliver care. DSS and the SIM PMO have agreed that Participating Entities in Wave 2 will be required to achieve the three CCIP core standards, in addition to meeting the requirements of PCMH+. The core standards focus on comprehensive care management, health equity improvement, and behavioral health integration. The elective standards are e-consults, comprehensive medication management, and oral health integration. A complete description of the CCIP core and elective standards can be found at the SIM website: www.healthreform.ct.gov/

The Final CCIP Report, including the Standards and Technical Assistance requirements, can be found at: http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/practice_transformation/ccip_standards/ccip_report_4-13-16_final_approved_3_30_16.pdf

Entities participating in the CMMI Practice Transformation Network (PTN) grant program (Funding Opportunity Number CMS-1L1-15-003, CFDA 93.638) are only required to achieve CCIP Core Standard Two: Health Equity Improvement (HEI), Parts 1 and 2. The requirements for CCIP and PCMH+ are described in the table below:

POLICY	CCIP REQUIREMENTS
CCIP commitment	PCMH+ RFP Respondents commit to participate in CCIP, which will be tailored to their individual needs, and to achieve the core CCIP standards within 15 months of the PCMH+ start date (anticipated to be 4/1/18). CCIP participation includes: • Participate in technical assistance, assessments, and the creation and implementation of a Transformation Plan to achieve core standards, and any chosen elective standards.

POLICY	CCIP REQUIREMENTS
	• Identify and deploy a committed leadership team. • Coordinate with the CCIP technical assistance vendors and participate in activities, including webinars, calls, on-site visits, trainings, and learning collaboratives. • Undertake a care delivery transformation process including engaging practices, modifying procedures, modifying workflows and IT systems, and providing clinical and quality improvement expertise and training to clinical staff. • Participate in a Community Health Collaborative. • Deploy care delivery interventions across all populations, regardless of payer, while ensuring the best interests of Medicaid beneficiaries.
PCMH+ RFP response requirements	PCMH+ RFP Respondents must complete Appendix C: CCIP Form
Funding	PCMH+ RFP Respondents other than those entities participating in the CMMI Practice Transformation Network (PTN) grant program will be required to participate in a learning collaborative and will have the opportunity to apply for up to $750,000 per applicant in SIM-funded transformation awards. *(Participating Entities that received Wave 1 Transformation Awards will be eligible to apply for supplemental awards.)* Entities participating in the PTN grant program will be required to participate in a learning collaborative and may have the opportunity to apply for small grants through SIM to support achievement of the Health Equity Improvement standard. **The RFP for funding will be released after the close of the PCMH+ RFP.**
Compliance monitoring	Respondents will participate in a validation survey; achievement of standards will be a condition of continued participation in PCMH+.
Accommodations	Providers may request a waiver or accommodations with respect to specific requirements. Accommodations can be found at: http://www.healthreform.ct.gov/ohri/lib/ohri/initiatives/ccip/ccip_report_accomodations_approved_20160330.pdf

13. Linkages with Community Partners to Address Prevention Service Needs

The SIM Prevention Service Initiative and related technical assistance are administered and provided by the SIM Program Management Office (PMO). The SIM Prevention Service Initiative aims to increase referrals between healthcare providers and community organizations to improve quality measures and health outcomes. Under this initiative, healthcare organizations enter into a written agreement with a community organization. The healthcare organization identifies and refers patients with unmet prevention needs, particularly related to asthma and diabetes, to the organization. The community

organization accepts the referrals and conducts an evidence-based, community-placed prevention service.

PCMH+ PEs will be required to enter into a written agreement with at least one community-based organization that has been selected to be part of the Prevention Service Initiative. PEs must meet this requirement if they have at least 500 attributed members in one of the three demonstration regions: Bridgeport, New Haven or Middletown. Written agreements should include at least one community based intervention targeting members of the PE's attributed population with one of the target conditions and associated social determinants of health. It is requested that PEs cooperate with the technical assistance process offered as part of the initiative to support successful partnerships. The technical assistance will emphasize demonstrated impact of the prevention services on quality measures that are part of shared savings arrangements.

Timeline: In the first quarter of calendar year 2018, a solicitation will be released for CBOs to participate in the Prevention Service Initiative. CBOs will be selected based on their capabilities and readiness to engage with the healthcare sector. The SIM Transformation Award solicitation will also be released in January 2018 for PEs to receive financial assistance to help offset the costs of their participation in the Prevention Service Initiative.

A qualified technical assistance (TA) vendor will engage with each PE, starting in April 2018. The TA vendor will focus on identify patients, modifying workflows, and contracting. PEs will be expected to initiate discussions with CBOs in the summer of 2018, to execute written agreements by November 1, 2018, and to demonstrate referral activity in accordance with these agreements on a quarterly basis beginning on December 1st, 2018.

Reporting: Once engagements with PCMH+ PEs for the Prevention Service Initiative begin, PEs must report the following through the regular PCMH+ reporting process:

- Description of the PEs programmatic approach including protocols for screening, assessment, referral and follow-up.
- Status of written agreement(s) with community-based organization(s) that are in the Prevention Service Initiative.
- Number of referrals to community-based organization(s) and program.
- Quarterly performance on quality and utilization measures selected by the PE.
- To the extent practicable, estimate associated projected costs and savings.

SIM Transformation Awards

SIM Transformation Awards are administered and provided by the SIM PMO. PCMH+ RFP Respondents who are approved to participate in the PCMH+ program as Participating Entities can submit a *separate* application for a SIM Transformation Award to offset costs associated with both CCIP and the Prevention Service Initiative, described above. A separate RFP for awards will be released after the close of the PCMH+ RFP by the SIM Program Management Office (PMO). Further instructions on how to apply for a SIM Transformation Award will be emailed to those who are approved to participate in the PCMH+ program.

	Eligible for SIM Transformation Awards		
Status	**To meet all CCIP standards** **(large award)**	**To meet health equity CCIP standard** **(small award)**	**For Prevention Service Initiative (PSI) community linkages***

New PCMH+ PE as of 4/1/18, not in PTN	✓		✓
New PCMH+ PE as of 4/1/18, in PTN		✓	✓

**Applicable to PCMH+ PEs with at least 500 attributed members in the Bridgeport, Middletown, or New Haven regions*

IV. PROPOSAL OUTLINE

- **A. COVER SHEET**
- **B. TABLE OF CONTENTS**
- **C. CLAIM OF EXEMPTION FROM DISCLOSURE**
- **D. CONFLICT OF INTEREST - DISCLOSURE STATEMENT**
- **E. EXECUTIVE SUMMARY**
- **F. MAIN PROPOSAL, TRACK 1 IS ADVANCED NETWORK (AN) AND TRACK 2 IS FQHC**

- **G. APPENDICES**
  - **Appendix A - FQHC Supporting Documentation**
  - **Appendix B - Advanced Network Lead Entity Supporting Documentation**
  - **Appendix C - Acknowledgement Statements**
  - **Appendix D - Advanced Network Confirmation**
  - **Appendix E - FQHC Confirmation**
  - **Appendix F - Advanced Network Provider Form**
  - **Appendix G - Letters of Intent**
  - **Appendix H - Subcontractors' Profile**
  - **Appendix I - Draft Subcontract(s)**
  - **Appendix J - CCIP Form**

- **H. FORMS**
  1. **Department**
     a. Addendum Acknowledgement(s)

     b. Certification Regarding Lobbying

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

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

     c. Form 7. Iran Certification Adobe.pdf Word.doc

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

V. ATTACHMENTS

A. PCMH+ QUALITY MEASURE SET

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

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

Reporting Only Measures	Measure Steward	National Quality Foundation #
Annual fluoride treatment ages 0<4	DSS	NA
Annual monitoring for persistent medications (roll-up)	NCQ	2371
Appropriate treatment for children with upper respiratory infection	NCQA	0069
Asthma Medication Ratio	NCQA	1800
Breast cancer screening	NCQA	2372
Cervical cancer screening	NCQA	0032
Chlamydia screening in women	NCQA	0033
Diabetes eye exam	NCQA	0055
Diabetes: medical attention for nephropathy	NCQA	0062
Follow-up care for children prescribed ADHD medication	NCQA	0108
Human Papillomavirus Vaccine (HPV) for Female Adolescents	NCQA	1959
Oral evaluation, dental services	ADA	2517
Use of imaging studies for low back pain	NCQA	0052
Well-child visits in the third, fourth, fifth and sixth years of life	NCQA	1516

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

B. CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

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

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

PrincipalStandard:

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

Governance, Leadership,and Workforce:

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

Communication and Language Assistance:

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

Engagement, Continuous Improvement, and Accountability:

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

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

www.ThinkCulturaiHealth.hhs.gov

THINK CULTURAL HEALTH

The Case for the Enhanced National CLAS Standards

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

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

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

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

Bibliography:

Beach, M. C, Cooper, L.A., ROOinson, K. A., Price, E. G. Gary, T. L. Jenckes, M. W., Powe, N.R. (2004). Strateges for imp-oving minority healthcare quality. (Al-RQ Pililcatioo No. 04-EOOS-02). Retneved !Tom the Agency of Health:oare Research and Quality web•te: htlp://www.ah'q.gov/downoads/p..ib/e'o1dence/pdf/mlnq.Jal/minq.Jal.pdf

Goode, T. D., D..me, M. C., & Brcrll€lm, S. M. (2006). The e deo:e base for cu tL«I and lingLJstic competEncy ln health care. (Commonwe<lth FLJnd Pililcation No. 962). Retrieved from The Commonwealth Fund website: http://www.commonweal thfund.org/usr_doc/Goode_evidencebasecUtiingUsticcomp_962.p::lf

LaVeist, T. A. Gaskin, D. 1 & Richard, P. (2009). The ec0110mic bLiden of health ineQ.Ja!ities in the Lhted States. Retrieved from the Joint Center for Poli tica' and Economic SLuJiewdJile: lrllp://www.juir rlcerrler.ury/ ile /JeraU L/IfUJL>luaJ/r beard t/flle(T1 re%20Eo:.>r10rri(.:o/o2 OOtrden%2Cklf%2a-le<lth%201necp.Jalities%20 n%20the%2CUitEd%20Stotes.pdf

National Partnership for Action tD End HeLJth Dsparities. (2011). National stokeh<>der strategy for ache>Ang health eCl-lty. Retrieved !Tom U.S. Department of Health 1nd Human Ser€es, Office of Minority Health websotE: htlp://www.minorityhealth.hhs.gov/rpa/tempates/oontent.aspxovi=!&lvild =33&10=286

U.S. Department of He<Jth and Human S€r\1ces. (2011). HHS action pan to recU:oe ramJ and ethrrc health dspanties: A r-ation free of dsparities in hea th and heath care. Retrieved !Tom htlp://mincrityhealth.hhs.gov/rpa/files/Flans/HHSfriHS_F1an_com petE.pdf

U.S. Department of He<Jth and Human S€r\1ces, Office of Dsease Prevention and Health Promotion. (2010). Healthy peq>e 2020: Social determir-ants of hea th. Retrieved from htlp://www.he<Jthypeq>e.gov/2020/topcsobjectives2020/over>Aew.aspxctopdd=39

U.S. Department of Health and Human Services, Office of Minority Health (2011). National Partnership for Action to End Health Dispa-ities. Retrieved &om htlp://mincrityhe<Jth.hhs.gov/rpa

1\\xld Health CXgarnation. (2012). Socia determinants of health. Retrieved<> m htlp://www.who.int/social_determlnants/en/

C. ADVANCED NETWORK PROVIDER FORM

Name of Advanced Network Lead Entity: _____

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

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

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

D. CCIP FORM

CCIP, SIM Transformation Awards, and related technical assistance (all as described below and elsewhere in this RFP) are administered and provided by the SIM PMO. Respondents must complete the following information related to the Clinical and Community Integration Program (CCIP). Please note that SIM Transformation Awards that help offset costs related to achieving the CCIP standards will be announced *after* the due date of the PCMH+ RFP. All selected PCMH+ PEs will be notified via email regarding the solicitation.

1. CCIP is comprised of three core standards (Comprehensive Care Management, Health Equity Improvement, and Behavioral Health Integration) and three elective standards (Oral Health Integration; E-Consults; Comprehensive Medication Management). PCMH+ PEs who are not participating in PTN will be automatically enrolled in free technical assistance for the three core standards. PCMH+ PEs that are participating in the PTN program will be automatically enrolled to receive technical assistance for the Health Equity Improvement standard.
2. PCMH+ PEs, including those who are participating in PTN, can also receive free technical assistance for three optional standards. Please indicate by check mark below if the Respondent is requesting technical assistance in support of any or all of the three elective standards:

    ☐ Oral Health Integration

    ☐ E-Consults

    ☐ Comprehensive Medication Management

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

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

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

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

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

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

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

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

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

i. ATTACHMENT: TRACK 1 MAIN PROPOSAL

TRACK 1: ADVANCED NETWORK (AN) Proposal Requirements for FIRST TIME RESPONDENTS

NOTEWORTHY: "Sections" referenced in the following AN requirements can be found in **Section III, PROGRAM INFORMATION**, **F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS** of this RFP.

Please be as brief as possible. Do not simply repeat the RFP requirements.

1. **Organization**

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

a. Overview

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

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

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

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

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

AN Lead Entities may respond to this RFP before finalizing formal agreements with provider organizations as an AN, so long as the response includes a plan of how the Respondent will finalize such formal agreements before the start of PCMH+ W2.

b. Service Delivery System

i. Describe the AN's service delivery system for all services provided to Medicaid beneficiaries, for each provider entity in the AN.

c. Governance

i. Describe the planned composition of the oversight body, how the body will be formed (including timeframes), and the planned functions and responsibilities of the oversight body, including how the AN will ensure that its governing board and/or other governing body will comply with the PCMH+W2 requirements for a governing body as detailed in the RFP in SECTION I.D. PROPOSAL FORMAT 7. Minimum Submission Qualification Requirements and SECTION III. F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 2. Organizational Requirements of PCMH+ Participating Entities (PE).

ii. Described all applicable contracts or similar formal documents that document the relationship between the various entities within the network and explain: (1) how these contracts and/or other documents enable the network to fulfill its mission, including coordinating care for individuals served by the network, (2) how these documents meet the requirements described in SECTION III PROGRAM INFORMATION F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 4.Enhanced Care Coordination Activities, (including, if applicable, how future and/or modified documents will meet those requirements), and (3) if applicable, how the network plans to add or change such documents and relationships in order to participate in PCMH+.

iii. Describe the Respondent's plans to ensure and promote transparency, community participation, and PCMH+ Member participation in the operation of PCMH+ programs and in major decisions through such methods as the Respondent deems appropriate, such as oversight body participation, focus groups, surveys, community meetings, engagement with community partners, and/or other areas, as determined by the Respondent.

iv. Describe the planned role and functions of the senior leader and clinical director.
Include the name of the individuals that will occupy these positions and their qualifications, and explain how those qualifications will enable these individuals to implement PCMH+ effectively.

d. Qualifications

i. Describe the Respondent’s overall qualifications to serve as a PCMH+ PE. Include a brief history of the organization, including number of years in operation, and all the strengths that the Respondent considers are an asset to the organization as an AN Lead Entity. Describe the strengths of any other providers that will be included in the AN.

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

e. References

Provide three (3) specific programmatic references for the Respondent.

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

References shall be able to comment on the following categories:

- Capability to implement PCMH+;
- Organizational approach; and
- Ability to problem-solve.

The reference should be able to briefly describe the Respondent’s performance in each category and then rate the Respondent’s performance as poor, fair, good, very good, or excellent in each category. The Department will disqualify any Respondent from

competing in the RFP process if the Department discovers that the Respondent had any influence on the references.

2. Enhanced Care Coordination Activities

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

a. Experience

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

b. Planned Approach

i. If the AN includes any primary care practice that is not a DSS PCMH practice, describe how the network will comply with the requirements in SECTION III PROGRAM INFORMATION F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS and D. Proposal Format 7.Minimum Submission Qualifications Requirements 7.b) ii. regarding plans to enable that practice to become a PCMH within the specified timeframes.

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

iii. For each of the required Enhanced Care Coordination Activities listed in SECTION III PROGRAM INFORMATION F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 4.describe the Respondent's plan for implementing the Enhanced Care Coordination Activities.

c. Care Coordinator Staff Requirements - The PCMH+ PE must provide required care coordination through individuals directly employed by, under contract to, or otherwise affiliated with the PCMH+ PE.

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

ii. Respondents shall select at least one (1) of the following options based on the model(s) that fit their practice and describe the plan to provide care coordination services with sufficient detail for DSS to be able to

evaluate whether it complies with the PCMH+W2.

(1) Employ a full time care coordinator dedicated solely to care coordination activities.

(2) Assign care coordination activities to multiple staff within a practice.

(3) Contract with an external agency to work with the practice to provide care coordination.

Additional Care Coordinator Information:

iii. To the extent available, list names, full time equivalent, and credentials of each Care Coordinator providing services on behalf of the PE and indicate if such individual is directly employed or contracted, or subcontracted by the PE. If a subcontractor is used, please acknowledge that and refer to the requirements in 6. Subcontractor(s), of this Track 1.

d. Community Linkages - Responses to this RFP will document how a Respondent proposes to implement and maintain meaningful partnerships with a wide variety of community partners, and how these partnerships will contribute to PCMH+ W2.

i. Describe any existing community linkages that already enable the Respondent to comply with SECTION III PROGRAM INFORMATION F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 10. Linkages with Community Partners to Address Social Determinants of Health, regarding community linkages.

ii. Describe the Respondent's plan to form new or enhanced community linkages under PCMH+ W2, including the name of any specific intended partner and the nature and purpose of the partnership. Include information on when these linkages/partnerships began and nature of the partnership. Please highlight linkages/partnerships with behavioral health and substance use organizations.

(1) Describe the expected impact of these partnerships on key outcomes related to PCMH+ W2.

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

3. Quality

A responsive proposal must include the following information about the Respondent's approach to improving quality of care.

a. Experience

i. Summarize the Respondent's experience and the experience of any other provider in the AN, implementing quality improvement initiatives. Describe key initiatives, including the goal of the initiative, the target population, and the outcomes achieved. Include detailed information on the types of reporting the Respondent utilizes to monitor its practice and track quality initiative outcomes.

b. Quality Program

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

c. Planned Approach

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

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

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

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

v. Describe how the Respondent will make reasonable efforts to assist their members in maintaining continuous eligibility for Medicaid to the extent such individuals continue to comply with applicable eligibility requirements.

4. Community and Clinical Integration Program

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

5. Data and Reporting

Please describe your **existing and planned** future capabilities for data collection, analysis, and reporting, especially regarding health quality measures and population health of your members and ongoing continuous quality improvement. To the extent possible, please provide specific data collection, analysis, and monitoring methods.

6. Subcontractors

If the Respondent is proposing the use of one or more subcontractors to provide all or part of the Care Coordinator services as part of its proposal, each subcontractor must be identified in the proposal. All subcontracts are subject to DSS' approval.

A responsive proposal must include the following information about each proposed subcontractor.

a. A Subcontractor Profile, which is embedded in this section as a hyperlink, shall be included in Section IV. Proposal Outline, H. Appendices, as **Appendix H, Subcontractor Profile**. The Subcontractor Profile must be signed by an authorized official of the proposed subcontractor.

b. A draft subcontract or other draft terms of agreement, if available, between the Respondent and the proposed subcontractor shall be included in Section IV. Proposal Outline H. Appendices, as **Appendix I, Draft Subcontract**. If such information is not yet available, please include an estimated full time equivalents, and job description for individuals subcontracted by the PE as **Appendix I.**

Selected Respondents shall be required to submit a copy of a final written agreement with each subcontractor prior to contract execution.

7. Financial Requirements

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

a. Accounting/Financial Reporting

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

b. Audited Financial Statements

   i. Submit one copy of each of the Respondent's three most recent annual financial statements prepared by an independent Certified Public Accountant, and reviewed or audited in accordance with Generally Accepted Accounting Principles. The copies shall include all applicable financial statements, auditor's reports, management letters, and any corresponding reissued components. **One copy only shall be included with the original proposal.**

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

c. Budget and Narrative

   i. A responsive proposal shall include costs associated with the program including staffing costs, fringe benefits, FTE, travel, supplies, potential vendor costs, contractual costs, direct/indirect costs, support costs.

   ii. When identifying these costs, the Respondent will also need to explain which of these resources are already present at the organization and would be repurposed and/or are already being funded in whole or part from one or more separate sources. Identify any other funding sources where monies will be spent on the program including gifts-in-kind. Potential cost over-runs, or possible cost increases the provider could/may experience during the performance year.

d. Shared Savings Distribution

   A responsive proposal must include the following information about the Respondent's plans for distributing any potential shared savings payments that may be received.

   i. Describe the manner in which the Respondent will distribute potential shared savings payments among providers in the AN.

   ii. Explain how the shared savings payment distribution methodology ensures that there is no factor within the methodology that would reward a provider for specific contributions to the overall savings of the network.

   iii. Describe how the Respondent will ensure that its means of allocating shared savings payments supports beneficiaries in receiving appropriate services, as evidenced by individual and aggregate quality measures and

measures of satisfaction.

iv. Describe how the Respondent plans to safeguard against, monitor for and remedy unintended consequences associated with its means of allocating shared savings, including, but not limited to, under-service, denial of service, and steering or actual transfer of patients within or outside its network.

ATTACHMENT TRACK 2 MAIN PROPOSAL

TRACK 2: FEDERALLY QUALIFIED HEALTH CENTER (FQHC) Proposal Requirements for FIRST TIME RESPONDENTS

NOTEWORTHY: "Sections" referenced in the following FQHC requirements can be found in **Section III, PROGRAM INFORMATION**, **F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS** of this RFP.

Please be as brief as possible. Do not simply repeat the RFP requirements.

1. **Organization**

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

a. Overview

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

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

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

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

b. Respondent's Service Delivery System

i. Describe the FQHC's service delivery system for all services provided to Medicaid beneficiaries. Describe the services the FQHC offers, the number of Connecticut Medicaid beneficiaries the FQHC serves, and the geographic area(s) served.

c. Governance

i. Describe what aspects of the FQHC's U.S. Health Resources and Services Administration (HRSA) designation provide protection to members and lend themselves to a governance structure in support of PCMH+, including relevant description about the actual composition, mission, and activities of the FQHC's board of directors and any other relevant committees or bodies affiliated with the FQHC and how the FQHC will ensure that its governing board and/or other governing body will comply with the PCMH+ W2 requirements for a governing body detailed in in the RFP in SECTION I.D. PROPOSAL FORMAT 7. Minimum Submission Qualification Requirements and SECTION III. F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 2. Organizational Requirements of PCMH+ Participating Entities (PE)

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

iii. Describe the planned role and functions of the senior leader and clinical director.

Include the name of the individuals that will occupy these positions and their qualifications, as well as explaining how those qualifications will enable these individuals to implement PCMH+ effectively.

d. Qualifications

i. Describe the Respondent's overall qualifications to serve as a PCMH+ PE. Include a brief history of the organization, including number of years in operation, and all the strengths that the Respondent considers are an asset to the organization as a FQHC.

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

e. References

Provide three (3) specific programmatic references for the Respondent. References shall be individuals who are able to comment on the Respondent's ability to perform the activities required by this RFP. References shall include the organization's name, the name of a specific contact person in the organization, a summary of the services the organization provides, and the mailing address, telephone number, and email address of a specific contact person. The reference shall be an

individual familiar with the Respondent and its day-to-day performance. References cannot be the Respondent's current employees, officers, directors, or principals. If the Respondent has provided services directly or indirectly through a contract or subcontract to the State within the past three (3) years, the organization shall include a State reference. The Respondent may include a Department reference in the proposal; however, the individual named may have to refuse if s/he will be involved in the evaluation of proposals received in response to this RFP. The Respondent may also include former Department staff as references. Respondents are strongly encouraged to contact their references to ensure the accuracy of their contact information, and their willingness and ability to provide references. The Department expects to contact these references as part of the evaluation process.

References shall be able to comment on the following categories:

- Capability to implement PCMH+;
- Organizational approach; and
- Ability to problem-solve.

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

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

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

a. Experience

i. Describe the Respondent's relevant experience in implementing care coordination for Medicaid or similar populations, including the types of care coordination interventions utilized, typical member engagement levels, and a description of the outcomes the Respondent has achieved.

b. Planned Approach

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

ii. For each of the required Enhanced Care Coordination Activities listed in SECTION III PROGRAM INFORMATION F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 4., describe the Respondent's plan for implementing the Enhanced Care Coordination Activity.

iii. For each of the Care Coordination Add-On Activities listed in Section III.F.5 of the PCMH+ DESCRIPTION & REQUIREMENTS, describe the Respondent's plan for implementing these required activities. Include specific details regarding the types of staff who function as the interdisciplinary team (with special focus on the behavioral care coordinator role), the frequency of interdisciplinary team meetings, and the content of these meetings.

c. Care Coordinator Staff Requirements - The PCMH+ PE must provide required care coordination through individuals directly employed by, under contract to, or otherwise affiliated with the PCMH+ PE.

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

ii. Respondents shall select at least one (1) of the following options based on the model(s) that fit their practice and describe the plan to provide care coordination services with sufficient detail for DSS to be able to evaluate whether it complies with the PCMH+ W2.

(1) Employ a full time care coordinator dedicated solely to care coordination activities.

(2) Assign care coordination activities to multiple staff within a practice.

(3) Contract with an external agency to work with the practice to provide care coordination.

Additional Care Coordinator Information:

iii. To the extent available, list names, full time equivalent, and credentials of each Care Coordinators providing services on behalf of the PE and indicate if such individual is directly employed or contracted, or subcontracted by the PE. If a subcontractor is used, please acknowledge that, and refer to the requirements in **6. Subcontractor(s) of this Track 2**.

d. Community Linkages - Responses to this RFP will document how a Respondent proposes to implement and maintain meaningful partnerships with a wide variety of community partners, and how these partnerships will

contribute to PCMH+ W2.

i. Describe any existing community linkages that already enable the Respondent to comply with SECTION III PROGRAM INFORMATION F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 10. Linkages with Community Partners to Address Social Determinants of Health, regarding community linkages.

ii. Describe the Respondent's plan to form new or enhanced community linkages under PCMH+ W2, including the name of any specific intended partner and the nature and purpose of the partnership. Include information on when these linkages/partnerships began and nature of the partnership. Please highlight linkages/partnerships with behavioral health and substance use organizations.

(1) Describe the expected impact of these partnerships on key outcomes related to PCMH+.

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

3. Quality

A responsive proposal must include the following information about the Respondent's approach to improving quality of care.

a. Experience

i. Summarize the Respondent's experience implementing quality improvement initiatives. Describe key initiatives, including the goal of the initiative, the target population, and the outcomes achieved. Include detailed information on the types of reporting the Respondent utilizes to monitor their practice and track quality initiative outcomes.

b. Quality Program

i. Describe the Respondent's current quality program(s) including annual goals and/or annual quality work plan. Ensure the quality program includes specific information regarding the PCMH recognized practices and their quality program and how they support any larger organization quality programs. Describe the quality model(s) utilized, the quality program's structure, names and purpose of quality committees along with committee membership, and describe all quality reporting conducted by the Respondent with reporting frequencies. Describe the Respondent's quality improvement process and provide the staffing chart for the quality program

if applicable or outline the staff and credentials with quality and performance improvement responsibilities. Include staff with responsibilities for maintaining the Respondent's Patient-Centered Medical Home recognition from NCQA or Primary Care Medical Home certification from The Joint Commission, as applicable to the Respondent.

c. Planned Approach

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

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

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

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

v. Describe how the Respondent will make reasonable efforts to assist their members in maintaining continuous eligibility for Medicaid to the extent such individuals continue to comply with applicable eligibility requirements.

4. Community and Clinical Integration Program

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

5. Data and Reporting

Please describe your **existing and planned** future capabilities for data collection, analysis, and reporting, especially regarding health quality measures and population health of your members and ongoing continuous quality improvement. To the extent possible, please provide specific data collection, analysis, and monitoring methods.

6. Subcontractor(s)

If the Respondent is proposing the use of one or more subcontractors to provide all or part of the Care Coordinator services as part of its proposal, each subcontractor must be identified in the proposal. All subcontracts are subject to DSS' approval.

A responsive proposal must include the following information about each proposed subcontractor.

a. A Subcontractor Profile, which is embedded in this section as a hyperlink, shall be included in Section IV. Proposal Outline, H. Appendices, as **Appendix H, Subcontractor Profile**. The Subcontractor Profile must be signed by an authorized official of the proposed subcontractor.

b. A draft subcontract or other draft terms of agreement, if available, between the Respondent and the proposed subcontractor shall be included in Section IV. Proposal Outline H. Appendices, as **Appendix I, Draft Subcontract**. If such information is not yet available, please include an estimated full time equivalents, and job description for individuals subcontracted by the PE as **Appendix I.**

Selected Respondents shall be required to submit a copy of a final written agreement with each subcontractor prior to contract execution.

7. Financial Requirements

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

a. Accounting/Financial Reporting

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

b. Audited Financial Statements

   i. Submit one copy of each of the Respondent's three most recent annual financial statements prepared by an independent Certified Public Accountant, and reviewed or audited in accordance with Generally Accepted Accounting Principles. The copies shall include all applicable financial statements, auditor's reports, management letters, and any corresponding reissued components. **One copy only shall be included with the original proposal.**

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

c. Budget and Narrative

A responsive proposal must develop budget analysis for spending of PMPM dollars and distribution of those dollars within the organization.

   i. A responsive proposal shall include costs associated with the program including staffing costs, fringe benefits, FTE, travel, supplies, potential vendor costs, contractual costs, direct/indirect costs, support costs.

   ii. When identifying these costs, the Respondent will also need to explain

which of these resources are already present at the organization and would be repurposed and/or are already being funded in whole or part from one or more separate sources. Identify any other funding sources where monies will be spent on the program including gifts-in-kind. Potential cost over-runs, or possible cost increases the provider could/may experience during the performance year. PMPM amount tracking methods, intended use for unspent funds at close of the year.

d. Shared Savings Distribution

A responsive proposal must include the following information about the Respondent's plans for distributing any potential shared savings payments that may be received.

i. Describe the manner in which the Respondent will distribute potential shared savings payments within the FQHC (including, but not limited to, any payments to practitioners affiliated with the FQHC).

ii. Explain how the shared savings payment distribution methodology ensures that there is no factor within the methodology that would reward a provider for specific contributions to the overall savings.

iii. Describe how the Respondent will ensure that its means of allocating shared savings payments supports beneficiaries in receiving appropriate services, as evidenced by individual and aggregate quality measures and measures of satisfaction.

iv. Describe how the Respondent plans to safeguard against, monitor for and remedy unintended consequences associated with its means of allocating shared savings, including, but not limited to, under-service, denial of service, and steering or actual transfer of patients.

THE STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

RESULT FILE

PROCUREMENT # PCMH+W2 RFP_1.8.2018

The evaluation process for the
Person-Centered Medical Home Plus Program Wave 2
Request for Proposals
(PCMH+W2 RFP)
is complete.

The Department of Social Services has offered the right to negotiate a contract to the following Respondents:

First Choice Health Centers, Inc.

Hartford Healthcare Medical Group, Inc.

Prospect CT Medical Foundation, Inc.

United Community and Family Services

Wheeler Clinic, Inc.