



**PROCUREMENT NOTICE**  
**State of Connecticut**  
**Department of Social Services**  
**Person-Centered Medical Home Plus Program Wave 3**  
**Request for Proposals (PCMH+W3 RFP)\_09062019**

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The State of Connecticut Department of Social Services (Department or DSS) is requesting proposals from qualified Federally Qualified Health Centers, Federally Qualified Health Center Look-Alikes (collectively, FQHCs), and Advanced Network (AN) Lead Entities (on behalf of ANs), as defined in this procurement, to become a Participating Entity (PEs) in Wave 3 of the Department's **Person-Centered Medical Home Plus Program (PCMH+ W3)**, the performance period for which will start on January 1, 2020 and run through December 31, 2021.

**Important Note: All prospective PCMH+ Wave 3 (W3) PEs (both ANs and FQHCs) are required to submit a proposal for PCMH+ W3, regardless of whether the PE participated in Wave 1 (PMCH+ W1) and/or Wave 2 (PCMH+ W2) of PCMH+.**

PCMH+ is care delivery reform initiative under which primary care practices that have already achieved Person Centered Medical Home (PCMH) recognition are required to implement additional features of care coordination. At the core, PCMH+ is about better service and care experience, as well as improved health outcomes, for Medicaid members. PCMH+ is a value-based payment reform initiative, under which the Department is continuing to make underlying fee-for-service (FFS) payments for services, but also is layering on pay-for-performance incentives under its PCMH initiative, (to eligible entities) advance care coordination payments, and Connecticut's first ever use of an upside-only shared savings approach.

PCMH+ supports effective and proven enhanced care coordination for Medicaid members through:

- engagement of members in oversight bodies, as a means of receiving their direct feedback and direction;
- expansion of care teams to include behavioral health supports and community health workers;
- integration of behavioral health within the workflow for medical care;
- primary care provider use of a data portal to inform responses their patient panels;
- continued work to develop, implement and share best practices in care coordination through an active, generative provider collaborative;
- continuous measurement of metrics that assess performance on key program priorities, most especially measures of successful care coordination and behavioral health integration; and

- strengthened connections with community-based organizations, as a means of addressing members' social determinant needs.

Enhanced care coordination requirements will be amplified in Wave 3 based on the results from extensive performance evaluations conducted by the Department during W1 and W2. Evaluation methods included on-site audits and program reviews, Medicaid member desk file reviews, monthly and quarterly surveys, Medicaid claim data reviews, as well as PE collaborative meetings. Evaluations, which will be carried forward into W3, helped the Department to identify both successes and challenges that require course correction, and to maintain focus on continuous learning and innovation. Lessons learned have led the Department to strengthen accountability standards related to care delivery, access, member experience, and quality improvement in W3. PEs that successfully achieve W3 program standards may receive shared savings as well as care coordination add-on payments for entities that are FQHCs.

PEs that were most successful in W1 and W2 used fully integrated, dynamic, interdisciplinary care teams that worked in collaboration across the organization. A growing body of national literature underscores the relationship between high quality teams and quality and safety in delivery of health care services. Recent data indicate that effective patient care coordination requires teamwork across multiple disciplines in order to provide whole person care. Ineffective care coordination and underlying suboptimal teamwork processes are a public health issue.<sup>1</sup> W3 participants will therefore be required to use on-site care coordination, and to expand of community health workers and other care coordinators in support of both medical needs and social determinants of health. Within the second year of the W3 performance period (calendar year 2021) of W3, PEs must demonstrate care team integration across practice site locations and continue to demonstrate improvements in quality.

PEs will be required to support members, and safeguard their interest in receiving timely, coordinated, and effective, medically necessary care. This must be substantiated by a low member opt-out rate, low rate of member complaints, and high incidence of members' positive reports of experience, as captured by Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. W3 PEs will be required to provide identified care coordination activities, to sponsor and or participate actively in a collaborative with local community partners, and to establish identified means of achieving feedback loops among medical and community partners. Feedback loops are an established, successful method that supports effective coordination of member care, supports identification of and fulfillment of social determinant needs, and promotes dialogue and trust among the partners.

Results from W1 and W2 clearly indicated that the most successful practices were those with fully integrated electronic medical records. Successful PEs were able to seamlessly share information between all members of the care team. PEs that saw the greatest improvements in quality, access, and member experience were those whose care teams could access members' complete medical records. In W3, all PEs will be required to have a universal electronic medical record that is accessible to all members of the care team. If a PE has multiple health record

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<sup>1</sup> Rosen, Michael A et al. "Teamwork in healthcare: Key discoveries enabling safer, high-quality care." *The American Psychologist* vol. 73,4 (2018): 433-450.

systems, that PE must be able to demonstrate seamless connectivity, communication, full interoperability of separate medical record systems, and accessibility to all care team members. This requirement must be met before the start of Wave 3 (January 1, 2020).

Advance care coordination payments and shared savings arrangements help promote improvements in members' health through better support for quality care and coordination, and also have the potential to contribute to reductions in overall costs as the health care system moves toward greater value.<sup>2</sup> Both nationally and in Connecticut, these models are being refined and adapted to address stakeholder concerns, increase provider participation and improve performance. Lessons learned from these early efforts help to inform the design and implementation of best practices for Medicaid programs.<sup>3</sup> Over the PCMH+ W1 performance period, Connecticut saw some quality measures improve while others did not show substantial change. This result is consistent with experiences in other care coordination programs. It is important to note that W1 reflected only a one year period, within which the initial cohort of PEs required start-up time, and many care coordination interventions are designed to achieve results not immediately, but incrementally over several years or more by improving overall health. In W3, PEs will be expected to continue to improve their results on quality measures. Further, the Department has modified the shared savings scoring methods for the purpose of rewarding both high performers and significant improvement. Performance gates have been added in W3 that will require PEs to improve year-over-year in avoidable hospitalizations and ED visits prior to qualifying for the Challenge Pool component of shared savings. Please see Section III. Program Information, F. Attachments, I of this RFP for the full list of quality measures that will be used in W3. A complete explanation of the shared savings calculation is found in Section III. Program Information of this RFP.

PCMH+ W1 resulted in aggregate MSR-adjusted savings to the Connecticut Medicaid Program calculated to be \$2,375,366, with two entities receiving shared savings payments in the Individual Saving Pool, and all entities receiving shared savings payments in the Challenge Pool. The performance period for PCMH+ W2 does not end until December 31, 2019. After that point, similar analysis of the above indicators will be completed and released. To ensure that PEs are making quality improvements as well as reaching targets in access, experience, and quality, W3 shared savings calculations will reward individual PEs a larger share of savings based on their performance as compared to their peers. Measures for simply maintaining quality have been removed from W3; PEs are expected to improve and be accountable to qualify for shared savings. PEs that are successful in reducing ED and avoidable hospitalizations will be able to participate in the Challenge Pool portion of shared savings. Challenge Pool awards will require PEs to improve overall performance year-over-year, and will be measured on four of seven quality measures. The Challenge Pool measures have been selected by the Department for the purpose of improved access and health status of Medicaid members.

PCMH+ W3 is expected to continue to improve health outcomes and care experienced by Medicaid members, and to contain the growth of health care costs, as measured by enhanced quality standards and a more rigorous shared savings methodology. Selected FQHCs and ANs will be accountable to provide care coordination activities that improve the quality, efficiency, and effectiveness of care delivered to Medicaid members. Failure to meet program standards may

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<sup>2</sup> S. Lawrence Kocot, Christine Dang-Vu, Ross White, and Mark McClellan. Population Health Management. Oct 2013.

<sup>3</sup> Milbank Q. 2019 Jun;97(2):583-619. doi: 10.1111/1468-0009.12386. Epub 2019 Apr 7.

result in the loss of advanced payments, corrective action plans, loss of shared savings awards, and potential dismissal from the PCMH+ program. Establishment of PCMH+ core standards is vital to the Department's long-term goal of migrating all of its primary care reforms, including PCMH, to value-based payment approaches over time. Best practice goals established in PCMH+ will assist by setting the standard and benchmark for PCMH as this program matures and develops.

If a PCMH+ PE meets specified quality performance standards, including under-service prevention requirements, and generates savings for the Connecticut Medicaid program, then that PCMH+ PE will receive a payment calculated using a shared savings methodology as described in SECTION III. PROGRAM INFORMATION. E. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS of this request for proposal (RFP). As noted above, this initiative involves upside-only risk in calculating the shared savings payments. PCMH+ PEs will not be required to return any share of increased expenditures incurred by Connecticut Medicaid. PEs that fail to meet performance standards risk loss of shared savings, enhanced care coordination payments, and risk corrective action plans issued by the Department.

**General Procurement Information.** A RFP Conference will be held on **September 12, 2019, 10:00am – 12:00pm Eastern Standard Time (EST)**. The deadline for submission of proposals is **2:00 pm EST on October 25, 2019**

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: [https://biznet.ct.gov/SCP\\_Search/Default.aspx?AccLast=2](https://biznet.ct.gov/SCP_Search/Default.aspx?AccLast=2)
- CT Department of Social Services' website at: <http://www.ct.gov/dss/rfp>

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

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## SECTION I. GENERAL INFORMATION

### A. INTRODUCTION

- 1. Request for Proposal Name.** Person-Centered Medical Home Plus Program, Wave 3, Request for Proposals (PCMH+ W3 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 AN Lead Entities (on behalf of ANs) to become PCMH+ PEs. The goal of PCMH+ W3 is to continue to improve the quality of care received, as well as the health outcomes and care experience of Medicaid members, while also containing the growth of health care expenditures.

The Department is excited to continue the Connecticut Medicaid PCMH+ Program. PCMH+ amplifies the important work of the Connecticut Medicaid PCMH program, and is also enabling the Department to shift its statewide care coordination efforts to a more local approach.

As of July 2019, 120 practices (affiliated with 534 sites and 2,124 providers) are participating in the PCMH program, serving 417,036 members (49% 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 (ASO)-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., high-risk pregnancy, sickle-cell disease, organ transplant, transgender services), 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+ 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 will meet the requirements of this RFP, including incorporating their own insights, experience, and creativity in

the shared goal 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+ W3 is guided by a number of important values:

- Protecting the interests of Medicaid members;
- Building on the platform of the PCMH program ([link to DSS PCMH program](#)), as well as the strengths and analytic capability of the Medicaid program's medical ASO;
- Learning from, and improving upon, PCMH+ Wave 1 and Wave 2
- Enhancing capacity at practices where Medicaid members are seeking care to improve health outcomes and care experience; and
- Addressing members' social determinant of health needs through care coordination and connections with local community-based organizations.

All Connecticut Medicaid members will be eligible for assignment to PCMH+ PEs, with the exception of the following:

- individuals who already receive extensive care coordination through other state and federal programs as detailed below;
- individuals who have another source of health care coverage; and
- those who qualify only for a limited Medicaid benefit.

PCMH+ PEs (FQHCs and ANs) will be required to provide Enhanced Care Coordination Activities as defined in SECTION III. PROGRAM INFORMATION.E. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS. Additionally, PCMH+ PEs that are FQHCs will be required to perform Add-On care coordination activities. PCMH+ PEs that are FQHCs will receive a Care Coordination Add-On Payment paid prospectively on a monthly basis for providing Care Coordination Add-On Payment Activities. 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 of this RFP. Contracts for PCMH+ PEs selected through this procurement are expected to begin on January 1, 2020 and run through December 31, 2021.

**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
AHRQ	Agency for Healthcare Research and Quality
ASO	Administrative Services Organization
BFO	Best and Final Offer
C.G.S.	Connecticut General Statutes
CAHPS	Consumer Assessment of Healthcare Providers and System
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
CT	State of Connecticut
CYSHCN	Children and Youth with Special Health Care Needs Department
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.)
LTSS	Long-term Services and Supports
MMIS	Medicaid Management Information System
MMDN	Medicaid Medical Directors Network
NA	Not Applicable



NCQA	National Committee for Quality Assurance
OAG	Office of the Attorney General (CT)
OHSU	Oregon Health & Science University
OPM	Office of Policy and Management (CT)
PCMH	Person-Centered Medical Home
PCMH+	Person-Centered Medical Home Plus Program
PHSA	Public Health Service Act
POS	Purchase of Service
PTN	Practice Transformation AN Grant Program
RFP	Request for Proposals
SEEC	State Elections Enforcement Commission (CT)
State	State of Connecticut
TAY	Transition Age Youth
U.S.	United States
WRAP	Wellness Recovery Action Plan

## Definitions

**Advanced Network or AN** A provider organization or group of provider organizations that provide Enhanced Care Coordination Activities to PCMH+ Members. At a minimum, an AN must include one or more primary care practices that are current participants in DSS' PCMH program (other than Glide Path practices). In addition to primary care practices, ANs may also include one or more specialty practices (including behavioral health and dental) as well as one or more hospitals.

In order to meet the definition of an AN, the AN must demonstrate the same standards across the entire AN to coordinate member care. ANs must perform as a complete system of care coordination, providing both clinical and social care coordination to members. ANs must be able to share and access all necessary electronic health record information needed to support the health, wellness, and care coordination of all PCMH+ members.

AN Lead Entity	A provider or provider organization that contracts with the Department on behalf of the AN and fulfills the functions specified in Section III. The AN Lead Entity must be a participating provider in the AN.
Attribution	Members are attributed to Medicaid-enrolled primary care providers based on a logic process created for use in the Department's PCMH initiative. Quarterly, the Department's medical ASO, CHNCT runs a Primary Care Provider (PCP)/PCMH attribution report that reflects member's claim information and supplemental data criteria over a retrospective period of fifteen (15) months. This process is one means of identifying members' usual source of care. Alternatively, a member who has affirmatively identified a specific provider as his or her PCP will be attributed to that provider, until another self-selection is made or claims indicate primary use of a different PCP. The process is used in order to share a member's claims information with their PCP. If a member cannot be attributed due to lack of claims, and has not self-selected a PCP/PCMH, he or she will remain unassigned for that annual attribution cycle.
Care Coordination Add-on Payments	Payments paid prospectively on a monthly basis to PCMH+ PEs 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+ PEs that are FQHCs are required to provide to PCMH+ Members in order to receive the Care Coordination Add-On Payment. These activities are described in Section III of this RFP. The Care Coordination Add-On Payment Activities are in addition to the Enhanced Care Coordination Activities required of all PCMH+ PEs.
Children and Youth with Special Healthcare Needs (CYSHCN)	Individuals age 0-17 years of age who meet the Maternal Child and Health Bureau's following definition of CYSHCN: "Those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." This definition is broad and inclusive, and it emphasizes the characteristics held in common by children with a wide range of diagnoses. Examples include children with diagnoses such as diabetes or asthma that is not well controlled.
Contractor	See PCMH+ PE.
Contract	The Contract awarded to the successful Respondents pursuant to this RFP.
Day	Calendar day.
Department or Agency	State of Connecticut Department of Social Services

Enhanced Care Coordination Activities	Required care coordination activities that all PCMH+ PEs must provide. These activities are described in Section III. 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+ PEs using the Department's PCMH retrospective attribution process, which has been adapted for PCMH+.
PCMH+ PE	An FQHC or AN (represented by the AN 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+ PEs and the performance of the PCMH+ initiative as a whole. Specific quality measures are used for reporting purposes only, and some are used to calculate an PCMH+ PE's quality performance as part of the shared savings calculations. The current set of the PCMH+ quality measures set can be found in Section III. Program Information, F. Attachments, I of this RFP, which is subject to change by the Department.
Performance Year or Performance Period	This is the time period during which the performance of the PCMH+ PEs will be evaluated for the purpose of the shared savings calculation.
Prior Year	The time period preceding the Performance Year. This period is used to establish the PCMH+ PEs' cost baselines 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.
Respondent	A provider organization (FQHC or AN Lead Entity on behalf of an AN) 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.

Transition Age Youth (TAY) Transition age youth are young people who are at high risk of not successfully transitioning into independent adulthood due to the complexity of their needs. The age range for transition age youth can vary between the ages of 16 and 25 years, and can also include children as young as 12 years of age.

Under-service Under-service means actions taken by or on behalf of a PE that have the result of limiting, excluding or discouraging one or more Medicaid members from seeking or receiving medically necessary Medicaid covered services, including, but not limited to, actions taken with the express or implicit goal of increasing savings generated by the PE, reducing the number of high-risk members assigned to the PE or both.

Wellness Recovery Action Plan (WRAP) 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.

### 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	Jean Miller
Address	State of Connecticut, Department of Social Services 55 Farmington Ave, Hartford, CT 06105-3730
Phone	(860) 424-4926
Email	DSS.Procurement@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:  
<https://portal.ct.gov/DSS/Services/Partners-and-Vendors/RFPs>
- State Contracting Portal:  
[http://www.biznet.ct.gov/SCP\\_Search/](http://www.biznet.ct.gov/SCP_Search/)

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:** \$6.3 million for PCMH+ W3 year one (January 1, 2020 through December 31, 2020); and \$6.3 million for PCMH+ W3 year two (January 1, 2021 through December 31, 2021). Each of these amounts represents the maximum amount of state and federal share combined of the Care Coordination Add-On Payments to PCMH+ PEs that are 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 ANs. The Department will not limit the number of qualifying Respondents from being selected as PCMH+ PEs.

**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:** January 1, 2020 through December 31, 2021.

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.** Individuals who are not duly formed entities incorporated in or registered to do business in Connecticut are ineligible to participate in this procurement. The Department reserves the right to reject the submission of any Respondent in default of any current or prior contract.
5. **Minimum Qualifications of Respondents.** To be qualified to submit a proposal in response to this procurement, respondent's organization must be an enrolled Connecticut Medicaid provider in good standing, and meet the additional minimum qualifications of a FQHC or an

AN as specified in the RFP Section I.D.5.

**6. Procurement Schedule.** Please note that all dates that are listed after the due date for proposals (“Proposals Due”) are estimated 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: September 6, 2019
- RFP Conference: September 12, 2019, 10:00am – 12:00pm EST
- Deadline for Questions: September 19, 2019, 2:00 PM EST
- Answers Released: October 3, 2019 (tentative)
- Proposals Due: October 25, 2019. 2:00 PM EST
- Start of Contract: January 1, 2020 (tentative)

**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. Early submission of questions is encouraged. Questions will not be accepted or answered verbally, either in person or over the telephone. All questions received before the deadline will be answered. However, the Department will not answer questions when the source is not identified. Questions that the Department determines to be 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 an LOI. 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 identified as material. The agency will release the answers to questions on the date established in the Procurement Schedule. The Department shall 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: September 12, 2019
- Time: 10:00 am, Eastern Standard Time
- 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:

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, Hartford, Connecticut. 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.

**11. 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

**12. 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."*

#### **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 in [Cover Sheet](#), 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.
4. **Executive Summary.** In Section IV. 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.
5. **Minimum Qualification Requirements.** Respondents must include the Executive Summary response, immediately above, as well as the following requirements, appropriate to a FQHC or an AN.
  - a) **Federally Qualified Health Center (FQHC) Supporting Documentation -** Provide the following documentation applicable to your organization in **Section IV. Proposal Outline, B.I.F, Supporting Documentation – 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 an equivalent level of recognition from NCQA under its 2017 and any future standards or Primary Care Medical Home certification from The Joint Commission.
  - b) **AN Lead Entities Supporting Documentation** Provide the following documentation applicable to your organization in **Section IV. Proposal Outline, B.I.F, Supporting Documentation – AN Lead Entity Supporting Documentation.**
    - i. Provide official communication from DSS documenting the participation of each of the providers within the AN that are a PCMH practice in the DSS PCMH program. All primary care provider practices in the AN must currently participate as a PCMH in the DSS PCMH program at the time that the entity submits its response to this RFP and the AN must document compliance with this requirement by completing the form describing its composition and showing that each primary care practice that is a

component of the AN is a participant in the DSS PCMH program. ANs are required to provide information requested in Section III. Program Information, F. ATTACHMENTS, III. AN PROVIDER FORM which identifies the makeup of the AN and validates practices as DSS PCMH certified.

- ii. Provide for AN Lead Entities, a description and accompanying supporting documentation to show that the AN Lead Entity is authorized to participate in this RFP on behalf of the AN, is authorized to enter into a potential contract as an PCMH+ PE on behalf of the AN, and has the ability to ensure that the AN complies with all applicable requirements, including, but not limited to all of the PCMH+ PE provider qualifications for ANs.
- c) **Acknowledgement Statements** To qualify for participation in PCMH+ W3, each PCMH+ PE, FQHC or AN is required to provide statements acknowledging that its organization adheres to the requirements listed below. Provide the following Acknowledgement Statements in **Section IV. Proposal Outline, B.I.F, Supporting Documentation – Acknowledgment Statements.**
- i. At the time of submitting the response to this RFP, each Respondent must 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 October 10, 2019. The Department's Official Contact will respond in writing to confirm the number of attributed PCMH members and also which practices within the PE 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 October 10, 2019, then members will not be assigned during the performance year, but may be reevaluated in later performance years.
  - ii. Ensure that providers participating in PCMH+ and providing services to Connecticut Medicaid members are enrolled in Connecticut Medicaid ([link to Connecticut Medical Assistance Program Provider Enrollment website](#)).
  - iii. Have an oversight body that may, but is not required, to overlap with an existing governing board or an existing advisory body. The oversight body must include substantial representation by 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. Have or develop a means to prevent, monitor, identify, and address under-service.
- 5) The PCMH+ PE must circulate material in advance of meetings of the oversight body, to its members. The PCMH+ PE must have formal procedures through which to seek, receive, and respond to feedback from the oversight body. Documentation of activities must be made available to DSS upon request.

d) **AN Confirmation Statement.** ANs must, at a minimum, provide a Confirmation Statement that the AN complies with the requirement listed below. Provide the Confirmation in ***Section IV. Proposal Outline, B.I.F, Supporting Documentation – AN Confirmation.***

- i. All primary care practices, including all individual primary care providers, participating as part of the AN must be current participants in the DSS PCMH program at the time that the entity submits its response to this RFP and must maintain the PCMH status in good standing throughout the AN's participation in PCMH+ (including hold/holds Level 2 or 3 Patient-Centered Medical Home recognition from NCQA or an equivalent level of recognition from NCQA under its 2017 and any future standards). Practices with Glide Path designation, which is a step towards DSS PCMH recognition, do not count as meeting this requirement. The AN must document compliance with this requirement by fully completing the form describing its composition, including all practice(s) that are components of the AN, specifying whether the practice is a primary care practice or a specialty practice and showing that each primary care practice that is a component of the AN is a participant in the DSS PCMH program. Section III. Program Information, F. ATTACHMENTS, III. AN PROVIDER FORM.

e) **FQHC Confirmation Statement** FQHCs must, at a minimum, provide a Confirmation Statement that the FQHC complies with the requirements listed below. Provide the Confirmation in ***Section IV. Proposal Outline, B.I.F, Supporting Documentation – 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.

**6. 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.

**7. 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: <b>PCMH+ W3.</b>
Dividers:	A tab sheet keyed to the table of contents must separate each subsection of the proposal; the title of each subsection must appear on the tab sheet.
Paper Size:	8½" x 11", "portrait" orientation
Print Style:	1-sided
Font Size:	Minimum of 11-point
Font Type:	Arial or Tahoma
Margins:	The binding edge margin of all pages shall be a minimum of one and one half inches (1½"); all other margins shall be one inch (1").
Line Spacing:	Single-spaced

**8. 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.

**9. 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: **PCMH+ W3.** Any received proposal that does not conform to these packaging or labeling instructions will be opened as general mail. Such a proposal may be accepted by the Department as a clerical function, but it will not be evaluated. At the discretion of the Department, such a proposal may be destroyed or retained for pick up by the Respondents.

## E. EVALUATION OF PROPOSALS

1. **Evaluation Process.** It is the intent of the Department to conduct a comprehensive, fair, and impartial evaluation of proposals received in response to this RFP. When evaluating proposals, negotiating with successful Respondents, and offering the right to negotiate a contract, the Department will conform with its written procedures for Purchase of Service (POS) procurements (pursuant to C.G.S. § 4-217) and the State's Code of Ethics (pursuant to C.G.S. §§ 1-84 and 1-85).
2. **Evaluation Team.** The Department will designate an Evaluation Team to evaluate proposals submitted in response to this RFP. The contents of all submitted proposals, including any confidential information, will be shared with the Evaluation Team. Only proposals found to be responsive (that is, complying with all instructions and requirements described herein) will be reviewed, rated, and scored. Proposals that fail to comply with all instructions will be rejected without further consideration. Attempts by any Respondent (or representative of any Respondent) to contact or influence any member of the Evaluation Team may result in disqualification of the Respondent.
3. **Minimum Submission Requirements.** All proposals must comply with the requirements specified in this RFP. To be eligible for evaluation, proposals must (1) be received on or before the due date and time; (2) meet the Proposal Format requirements; (3) follow the required Proposal Outline; (4) be complete and (5) meet the requirements listed in Minimum 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. The weights are confidential. The criteria are weighted according to their relative importance. Only the criteria listed below will be used to evaluate proposals:
  - Organization
  - Enhanced Care Coordination Activities and Care Coordination Add-On Activities
  - Quality
  - Data and Reporting
  - Subcontractor(s)
  - 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).

## SECTION 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: <http://www.ct.gov/opm/cwp/view.asp?a=2981&q=382982>

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](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](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).**

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](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.

## SECTION III. PROGRAM INFORMATION

### A. DEPARTMENT OVERVIEW

The Department of Social Services - Connecticut's multi-faceted health and human services agency - delivers and funds a wide range of programs and services. DSS serves about 1 million residents of all ages in all 169 cities and towns, supporting the basic needs of children, families and individuals, including older adults and persons with disabilities. With service partners, the agency provides health care coverage, food and nutrition assistance, financial assistance, child support services, energy aid, independent living services, social work services, protective services for the elderly, home-heating aid, and additional vital assistance. By statute, the Department is the single State agency responsible for administering Connecticut's Medicaid program.

#### **Department Mission**

Guided by our shared belief in human potential, we envision a Connecticut where all have the opportunity to be healthy, secure and thriving.

#### **Department Vision**

We, along with our partners, provide person-centered program and services to enhance the well-being of individuals, families and communities.

### 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: 1) a streamlined administrative Medicaid structure; 2) access to primary, preventative care; 3) integration of behavioral and medical care; and 4) rebalancing of long-term services and supports. For more detail on the HUSKY Health reform agenda, please see:

<https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Communications/10-Things-to-Know-About-HUSKY-Health-November-2018.pdf?la=en>

### C. PCMH+ OVERVIEW

An overview of PCMH+ is described in SECTION I. GENERAL INFORMATION.

#### **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+ PEs for a contract period beginning January 1, 2020 and ending December 31, 2021

#### **D. INTENSIVE CARE MANAGEMENT (ICM)**

PCMH+ PEs are responsible to provide care coordination and identification of social determinant needs for members in their practice, including those individuals are participating in the medical ASO's ICM program as of the start of PCMH+ W3. The only exceptions to this rule are as follows:

- 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, sickle-cell disease, organ transplant, transgender services) will remain supported by the medical ASO's ICM services.

CHNCT will warn transfer members to relevant PCMH+ PEs for PCMH+ care coordination. 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.

#### **E. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS**

PCMH+ W3 builds on DSS' existing PCMH program and lessons learned during PCMH+ W1 and W2 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 with the aim of improving the quality, efficiency, and effectiveness of Medicaid services. All PCMH+ PEs (both FQHCs and ANs) 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 Payments to PCMH+ PEs that are FQHCs to support Care Coordination Add-On Payment Activities as outlined

below.

PCMH+ PEs 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. Care coordination team members must be easily accessible for the member as well as all members of the interdisciplinary team for seamless care coordination and best practices standards.

#### **1. Organizational Requirements of PCMH+ PEs**

To be eligible to participate in the PCMH+ W3 RFP, Respondents must meet the minimum requirements for all PCMH+ PEs plus the criteria for either a FQHC or an AN, as applicable to the Respondent. **These minimum qualification requirements are listed in:**

#### **SECTION I. GENERAL INFORMATION, D. PROPOSAL FORMAT 5. Minimum Submission Qualification Requirements, and are required of the Respondent to submit a proposal.**

The Department will only enter into contracts under PCMH+ with FQHCs and AN Lead Entities (on behalf of ANs) that meet minimum requirements. PCMH+ PEs may have common or diverse ownership. Diverse ownership means that the PCMH+ PE is 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 5. Minimum Qualification Requirements each PCMH+ PE must also meet the following requirements:

- a. PCMH+ PEs must provide assistance to PCMH+ Members to enable them to attend oversight body meetings (including assistance with transportation and childcare).
- b. PCMH+ PEs must circulate materials to members in advance of meetings of the oversight body.
- c. PCMH+ PEs must have formal procedures through which to receive, document and respond to feedback from the oversight body and must make such documentation available to DSS upon request.
- d. PCMH+ PEs must ensure that the required Enhanced Care Coordination Activities are implemented as intended, including but not limited to ensuring that required staff are hired and appropriately trained, monitoring day-to-day practice, establishing linkages with community partners, and all required reporting to DSS.
- e. PCMH+ PEs must enter into contracts with DSS.
- f. PCMH+ PEs must identify a clinical director and a senior leader to represent the PE and to champion PCMH+ goals. These positions are not required to be full time or solely dedicated to PCMH+. The appointment and, if necessary, removal of the clinical director and senior leader must be subject to advance input and advice from the oversight body.
- g. PCMH+ PEs must receive any shared savings achieved and distribute the shared



savings to participating providers within the PE, using a written distribution methodology that is subject to advance review and approval by the Department and will be documented in the PE's contract with the Department.

- h. PCMH+ PEs have discretion and flexibility in designing their distribution methodology for shared savings payments. For example, a PE 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. However, PCMH+ PEs must not distribute shared savings payments, if any, to any individual physician, APRN or physician assistant within the PE using any factors that would reward such individual for that individual's specific contributions to the overall savings generated by the PE.
- i. PCMH+ PEs must not engage in any activities designed to result in selective recruitment and attribution of members for the purposes of improving the probability of achieving savings and/or demonstrating compliance with under-service prevention requirements.
  - 1) In addition to complying with all requirements that apply to all PCMH+ PEs and the Minimum Qualification Requirements referenced above, ANs must also:
    - a) All primary care practices (including all individual primary care providers) participating as part of the AN must be current participants in the DSS PCMH program as a PCMH as of the time the entity responds to the RFP and throughout the AN's participation in PCMH+ (including hold/holds Level 2 or 3 Patient- Centered Medical Home recognition from NCQA or an equivalent level of recognition from NCQA under its 2017 and any future standards). 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 AN and cannot change during a Performance Year, except that upon request from an AN Lead Entity, as described in more detail below, the Department may approve changes for PCMH+ purposes to reflect changes that occurred in the composition and structure of the AN, such as due to mergers, acquisitions, dissolutions, sale, and other changes in the formal affiliation of components of and within the AN.
    - b) ANs are encouraged to include additional providers, must include signed letters of intent for each provider included in the AN in the RFP response. Acceptable options for AN 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).

- c) Designate an AN Lead Entity that is a provider or provider organization participating in the AN. If the AN is comprised of more than one provider organization, have a formal written contractual relationship with all other AN participating providers for the purposes of PCMH+. The contract must at a minimum contain:
1. An explicit requirement that each AN participating provider agrees to participate in and comply with the applicable requirements of the PCMH+;
  2. A description of the AN participating provider's rights and obligations in, and representation by, the AN Lead Entity, including language giving the AN Lead Entity the authority to terminate a provider's participation in the AN for its non-compliance with the AN participation agreement or any of the requirements of Connecticut Medicaid;
  3. Language that AN participating providers must allow PCMH+ Members freedom of choice of provider and that PCMH+ members will continue to be eligible for all services covered by the Connecticut Medicaid Program.
  4. Designate and agree to use of a single EMR or utilize interoperable arrangements to enable seamless sharing of health information for efficiency and improved quality of member care. A PCMH+ member's medical record and electronic health information must be accessible to all care coordination team members for care coordination purposes.

**Please Note:**

- i. Subject to the Department's review and approval, an AN is permitted to alter its composition of participating health care entities and/or community partnerships at any time, so long as the AN continues to meet all PCMH+ requirements. The AN must promptly inform DSS in writing of any such proposed changes and provide relevant documentation, and must obtain DSS approval in advance of implementing the change for purposes of its participation in PCMH+.
- ii. Individual medical providers are not obliged to remain with an AN through the end of the calendar year and can leave PCMH+ at any time. However, if an entire PCMH leaves an AN any members assigned to that PCMH will be removed for purposes of calculating any applicable shared savings payment.
- iii. DSS understands that ANs 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+ AN but could provide services to the member without the AN violating PCMH+ requirements. However, the AN 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 is individually enrolled in Medicaid.

## 2. Retrospective Attribution and Prospective Assignment Methodology

Eligible Medicaid members will be assigned to PCMH+ PEs using the retrospective attribution methodology that is used for primary care providers in Connecticut's Medicaid program and for the PCMH program. The PCMH retrospective attribution methodology attributes a Medicaid member to a PCMH based on the member's active choice of provider (i.e., usual source of care). 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+. AN must provide all information in Section III. Program Information, F. Attachments, III. AN PROVIDER FORM. Eligible Medicaid members will be assigned to a PCMH+ PE in October 2019 for PCMH+ W3 starting January 1, 2020.

PCMH+ Members are notified at the start of each performance period that they retain the following rights:

- the right to choose to see any qualified Medicaid provider;
- continued eligibility for all services covered by the Connecticut Medicaid program, including those not included in the shared savings calculation; and
- the right to opt-out of assignment to PCMH+ at any time.

If an eligible Medicaid member 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 member opts-out of the PCMH+ and that member's assigned PCMH+ PE was an FQHC, then that FQHC will no longer receive the Care Coordination Add-On Payment for that member.

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.

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

- a. Behavioral Health Home (BHH) participants and participants in any other health home program that may be established by the Department pursuant to section 1945 of the Social Security Act.
- b. Partial Medicaid/Medicare dual eligible members; individuals participating in Medicare Accountable Care Organizations (ACOs); and individuals enrolled in Medicare Advantage (MA) plans.
- c. Home and community-based services participants served under sections 1915(c) , 1915(i), and 1915(k) of the Social Security Act.
- 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 Medicaid 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.

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+ PEs make reasonable efforts to assist eligible members in maintaining continuous eligibility for Medicaid.

### **3. Enhanced Care Coordination Activities**

PCMH+ PEs are required to 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+ PEs 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 ANs:

- a. Behavioral Health/Physical Health Integration, which requires that PCMH+ PEs:
  - 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 screen, in both medical and behavioral health visits, for behavioral health conditions including, but not limited to, depression.
  - iii. Promote universal screening for behavioral health conditions across all populations, not just those traditionally identified as high risk.
  - iv. Engage in discussions with members with behavioral health conditions about psychiatric advance directives and:

- a. document these discussions in members' files;
  - b. determine whether members already have such documents, and if so, place them in members' files; or
  - c. support members who wish to do so in preparing a psychiatric advance directive.
- v. Engage in discussions with members with behavioral health conditions about Wellness Recovery Action Plans (WRAPs) or other behavioral health recovery planning tools and:
- a. document these discussions in members' files;
  - b. determine whether members already have WRAPs, and if so, place them in members' files; or
  - c. support members who wish to do so in preparing a WRAP.

**Note:** 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, which requires that PCMH+ PEs:
- i. Require annual cultural competency training for all practice staff. Cultural competency trainings must address the unique needs of individuals with disabilities and may be coordinated with the required training regarding individuals with disabilities described below.
  - ii. Expand any individual care plan tool that is currently in use to include an assessment of the impact culture has on health outcomes.
  - iii. Comply 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 Section III. Program Information, F.Attachments, II for the CLAS standards).
- c. Care Coordinator Staff Requirements, which requires that PCMH+ PEs:
- i. Provide required care coordination through individuals directly employed by, under contract to, or otherwise affiliated with the PCMH+ PE. The PCMH+ PE 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. To fulfill care coordination staffing requirements, PCMH+ PEs must:
    - a. Employ a full time care coordinator dedicated solely to care coordination activities;
    - b. Assign care coordination activities to multiple staff within a practice; or
    - c. Contract with an external agency to work with the practice to provide care coordination.
    - d. Ensure care teams are easily accessible to Medicaid members,

located on-site.

- e. Effective patient care coordination requires teamwork across multiple disciplines in order to provide whole person care. PEs must expand the role of the community health-workers when possible and support full integration of interdisciplinary teams across the entire organization.
- d. Children and Youth with Special Healthcare Needs (CYSHCN), which requires that PCMH+ PEs:
- i. Engage in and document in the electronic health record the discussion of advance care planning for CYSHCN. Advance care planning is not limited to CYSHCN with terminal diagnoses. It should also be considered for 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. Engage in discussions with children and families about accommodation of members' needs in school settings.
  - iv. Document such discussion in the member's health assessment and health record.
  - v. Include school related information recorded in members' health records, including as applicable:
    - A. Individualized education plan (IEP) or 504 plan;
    - B. Any special accommodations needed in the school environment;
    - C. Documentation of any advocacy supports needed by the child or family;
    - D. Records related to the child's performance in school and how many days have been missed due to the child's health condition;
    - E. Documentation of the school name and primary contact; and
    - F. Any other related school information that may assist the PCMH+ PE with care coordination efforts.
- e. Competencies in Care of Individuals with Disabilities (inclusive of physical, intellectual, developmental and behavioral health needs), which requires that PCMH+ PEs:
- i. Expand their health assessments to include questions about physical and communication accommodations needed during medical visits.
  - ii. Adjust appointment times and provide other needed supports for individuals who require additional time to address physical accommodations, have communication or other needs.
  - iii. Develop and require mandatory disability competency trainings for PCMH+ PE staff to address the care of individuals with physical and intellectual disabilities, which may be coordinated with the cultural competency training described above.
  - iv. Acquire accessible equipment to address physical barriers to care (e.g., wheelchair scales, 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. Include on the PCMH+ PE's resource list of community providers who specialize in or demonstrate competencies in the care of individuals with disabilities.

**4. Care Coordination Add-On Activities**, which requires that PCMH+ PEs that are FQHCs to perform the following Care Coordination Add-On Payment Activities:

- a. 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 member and family.
- c. Develop and implement care plans for TAY (e.g., collaborative activities to achieve success in transition and/or referrals to and coordination with programs specializing in the care of TAY).
- d. Use an interdisciplinary team that includes behavioral health specialist(s), including the required behavioral health coordinator position, and that has the capacity to fully integrate across the entire organization to facilitate member care.
- e. Physical and behavioral health integration, conduct interdisciplinary team case review meetings at least monthly, promote shared appointments and develop a comprehensive care plan outlining coordination of physical and behavioral health care needs.

**5. Quality Strategy and Quality Measure Set**

The current set of PCMH+ quality measure set can be found in **Section III.F as Attachment I** 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. The Department may modify the list of quality measures prior to the start of a Performance Year, with 30 days advance notice to the PEs.

## **6. Under-Service Prevention Requirements**

Under-service is specifically prohibited under PCMH+. There is a potential risk in a shared savings model that providers may have a financial incentive for members to be 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 order to address this risk, each PE must implement means of preventing underservice, and remedying any incidence of under-service that may occur, including educating staff regarding how to prevent under-service.

## **7. Overview of Payment Methodology**

PCMH+ includes two types of payments: Shared savings payments (Individual Pool payments and Challenge Pool payments) and prospective Care Coordination Add-On Payments. Care Coordination Add-On Payments will only be made to PCMH+ PEs that are FQHCs.

Both FQHCs and ANs will receive fee-for-service (FFS) payments, any other enhanced payments under the Connecticut Medicaid program for which they are eligible, consistent with 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 investments in 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 that are FQHCs, and the number of Medicaid members assigned to these PEs. If this funding is exhausted during a performance year, no further Add-On Payments will be made.

- i. The roster of members assigned to a given PE may change from month to month. Members may choose to opt out of the program, may fall into a PCMH+ excluded category, or may lose HUSKY eligibility. Care Coordination Add-On Payments will only be made for members who are attributed in the month in which the payment is made. Members who are reinstated to HUSKY eligibility within 60 days of loss of coverage, and whose enrollment is on that basis continued to be continuous will qualify for a retroactive payment for the months in which the add-on payment was not made. Members who become ineligible for Medicaid, but return to HUSKY eligibility will not receive care coordination from the PE during the period of their ineligibility, and the FQHC to which the member was assigned will not receive Care Coordination Add-On Payments for that period. After the member again becomes eligible, care coordination and Care Coordination



Add-On Payments will resume. Only members who have had at least eleven (11) months of eligibility (including retroactive eligibility) in each calendar year (Prior Year and Performance Year) will be included in the PCMH+ shared savings calculation.

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 levels of savings, if any, cannot be predicted in advance, it is not possible to estimate shared savings payments prospectively. Shared savings payments, if applicable, will be made after the close of the PCMH+ program year (on or about late calendar year 2021 for the Performance Year of calendar year 2020). PCMH+ PEs must achieve quality standards in order to be eligible for shared savings payments. PCMH+ PEs that do not meet the quality standards of eligibility will forfeit any savings generated. Shared savings payment methodology is premised on the following guiding principles:

- Only PCMH+ PEs that meet quality standards and under-service prevention requirements will be eligible to participate in shared savings.
- Only PCMH+ PEs that improve on the Avoidable ED Visits and Avoidable Hospitalizations quality measures will be eligible to receive shared savings in the Individual Savings Pool or Challenge Pool.
- PCMH+ PEs will be disqualified from receiving shared savings if any of their providers are found to be underserving or manipulating their panel.
- Absolute Quality performance and quality improvement from the Prior Year to the Performance Year 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. Quality targets will be derived from prior performance of all PCMH+ PEs and improvement in the Performance Year. Cost benchmarks will be derived from non-PEs in the state.

If a PCMH+ PE generates savings for the Connecticut Medicaid program and meets applicable measures of quality and under-service prevention requirements, then that PCMH+ PE will share in up to 50% of the savings achieved. Savings will be available to PCMH+ PEs through two savings “pools”. The first pool is an Individual Savings Pool, through which each PCMH+ PE that meets quality benchmarks will receive a portion of the savings that it achieved individually. The second pool is a Challenge Pool that will aggregate all savings not awarded to individual PCMH+ PEs from the Individual Savings Pool. The Challenge Pool may not be funded if Individual Savings Pool payments meet or exceed the savings for the entire program (including credible losses).

Participation in the Individual Savings Pool and Challenge Pool is based on a PCMH+

PE's improvement on the Avoidable ED Visits and Avoidable Hospitalizations quality measures. If PCMH+ PEs fail to improve in both quality measures, they will not be able to participate in the Individual or Challenge Pool. For PCMH+ PEs that are eligible for the Challenge Pool, awards will be based on performance and improvement on four of seven quality measures. PCMH+ PEs will identify which four challenge measures they will be scored on and measure selection must take place before the start of the program period. Final measure selection is subject to the DSS approval. The PCMH+ PE selection of Challenge Measures does not result in immediate or easy reward for PEs. The Challenge Pool Score is based on performance and improvement for PE-selected Challenge Quality Measures. PCMH+ PEs who fail to achieve both high performance and improvement on all measures will result in reduced Challenge Pool awards.

I. Shared Savings Cost Calculations

a. Benefits Included in the Shared Savings Calculation:

Each PCMH+ PE's shared savings calculation includes the cost of a defined set of Medicaid benefits for all PCMH+ PEs. PCMH+ PEs are not required to deliver all benefits. The cost of these benefits will be included in the PCMH+ PE's shared savings calculation. PCMH+ PEs have the opportunity to influence the cost of benefits by coordinating members' needed services and by addressing social determinants of health through linkages to community partners.

All Medicaid claim costs for covered benefits will be included in the shared savings calculation for each PCMH+ PE, with the exception of hospice; long-term services and supports, including institutional and community-based services; waiver services; and Non-Emergency Medical Transportation. PCMH+ Members remain eligible for all benefits covered by the Connecticut Medicaid program, including those listed above that are excluded from the shared savings calculation, and will continue to have the right to see any qualified Medicaid provider of their choice.

b. Shared Savings Model Components:

A PCMH+ PE will receive its shared savings payments, if any, from the Individual Savings Pool in accordance with the model components described below:

- Each PCMH+ PE Individual Savings Pool shared savings payments will be funded by savings for the Connecticut Medicaid Program that were demonstrated for the PE's assigned PCMH+ members during the Performance Year. If no savings are demonstrated, no payments will be made in the Individual Savings Pool for that PCMH+ PE.
- As detailed immediately below, each PE's 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.
  - Minimum Savings Rate: A PCMH+ PE's risk-adjusted savings must meet the MSR requirement, which is greater than or equal to

2% of the Risk Adjusted Expected Performance Year Costs. If a PCMH+ PE meets the MSR requirement, then first-dollar savings (i.e., all savings generated including amounts below the MSR threshold) will be treated as savings.

- Savings Cap: A PCMH+ PE's savings will be capped at 10% of Risk Adjusted Expected Performance Year Costs and any savings above 10% will not be included in the PE's Individual Savings Pool.
- Sharing Factor: If a PCMH+ PE has savings based on the above criteria, savings will be multiplied by a Sharing Factor of 50%. The resulting amount will form the basis of the PCMH+ PE's Individual Savings Pool which will then be adjusted for the PCMH+ PE's quality performance.
- For each PCMH+ PE, calculation of savings will be based on the extent to which the PCMH+ PE achieved a lower cost trend than the statewide non-PE comparative cost trend.
- Calculations are limited to PCMH+ members who remain assigned and maintain at least 11 months of Medicaid Eligibility for both the Prior Year and the Performance Year. Cost data for 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 claim costs will be truncated at \$100,000. This means that expenses above \$100,000 will not be included in the shared savings calculation.
- Risk adjustment methods will be used to adjust both Prior Year and Performance Year costs for underlying differences in illness burden. Each member will receive a risk score for the Prior Year and a risk score for the Performance Year. These risk scores will be aggregated for each PCMH+ PE to measure the change in illness burden from the Prior Year to the Performance Year.
- A PCMH+ PE's Risk Adjusted Expected Performance Year costs will be developed by trending forward the PCMH+ PE's Risk Adjusted Prior Year Cost by the statewide comparative cost trend. A PCMH+ PE's savings will be the difference between its Risk Adjusted Expected Performance Year costs and its actual Risk Adjusted Performance Year costs. PCMH+ PEs that demonstrate losses (i.e., higher than expected expenditures for members assigned to the PE) will not return these losses.

## II. Individual Savings Pool

### a. Individual Savings Pool Eligibility:

PCMH+ PEs must improve year-over-year performance on the Avoidable ED Visits and Avoidable Hospitalizations quality measures in order to be eligible to receive shared savings in the Individual Savings Pool or Challenge Pool. Any PCMH+ PE that does not improve, satisfy this requirement will forfeit any savings generated in the Individual Savings Pool and will be ineligible to receive any funds

from the Challenge Pool.

b. Individual Pool Funding

Each PCMH+ PE's Individual Savings Pool shared savings payments, if any, will be funded by the savings demonstrated for the PCMH+ members assigned to that PCMH+ PE. The PCMH+ PE's shared savings payment in the Individual Savings Pool will be determined by the PCMH+ PE's Total Quality Score. The Total Quality Score will be developed based on the PCMH+ PE's quality scores (Absolute Quality) and improvement on quality scores (Improve Quality) included in **Section III.F as Attachment I**.

The 12-month period of the first Performance Year will be January 1, 2020 through December 31, 2020, and the Prior Year will be January 1, 2019 through December 31, 2019. The second Performance Year will be January 1, 2021 through December 31, 2021 and the Prior Year will be January 1, 2020 through December 31, 2020.

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 statewide cost trend to be derived from non-PEs. Savings will only be calculated based on PCMH+ members who remain eligible for PCMH+ for at least 11 months of both the Performance Year and Prior Year. Risk adjustment methods will be used to adjust both Prior Year and Performance Year costs for underlying differences in illness burden.

c. Individual Pool Quality Scoring:

The PCMH+ PE's shared savings payment from its Individual Savings Pool is based on the PE's score on quality measures as described below. Each quality measure can generate a maximum of two points — one point for the absolute level of quality achieved and one point for the year-over-year improvement in quality, as detailed below:

1. Absolute Quality: For each quality measure, a PCMH+ PE will earn a maximum of one point in accordance with the table below for its ability to reach Absolute Quality targets in the Performance Year.

The 2020 Absolute Quality targets will be derived from the 75<sup>th</sup> percentile of all PCMH+ PE quality scores from 2018. The 2021 targets will be derived from the 75<sup>th</sup> percentile of all PCMH+ PE quality scores from 2019. These targets will be shared with each PE.

<b>Quality Performance Measured Against Quality Target</b>	<b>Points Awarded</b>
Between 0.00% and 74.99%	0.00
75.00% or greater	1.00

2. Improve Quality: For each quality measure, a PCMH+ PE will earn a maximum of one point in accordance with the table below based on its year-over-year improvement compared to the improvement for all of the PCMH+ PEs. The table for each measure will be derived from all PEs for each Performance Year.

Quality Improvement Measured Against All PEs	Points Awarded
Between 0.00% and 49.99%	0.00
50.00% or greater	1.00

To calculate each PCMH+ PE's Total Quality Score, its points will be summed and then divided by the maximum number of points possible. The Total Quality Score, expressed as a percentage, will be used in calculating the portion of a PCMH+ PE's Individual Savings Pool that is earned by the PCMH+ PE as shared savings.

For example, if a PCMH+ PE scored above the 75<sup>th</sup> percentile for five quality measures for Absolute Quality, it would earn five points for Absolute Quality. If the same PE scored above the 50<sup>th</sup> percentile for seven of the nine quality measures in Improve Quality, it would earn seven points for Improve Quality, resulting in 12 points in total. Since 18 points are possible, the PCMH+ PE would receive a Total Quality Score of 66.67% ( $12/18 = .6667$ ).

### III. Challenge Pool

#### a. Challenge Pool Funding:

Any calculated savings amounts not paid as shared savings payments in the Individual Savings Pool will be aggregated to form the Challenge Pool. The Challenge Pool funding is available provided that the Challenge Pool payments when combined with the Individual Savings Pool payments do not exceed the Aggregate Savings of the PCMH+ program for a Performance Year.

Performance on a unique set of challenge measures, listed in **Section III.F as Attachment I**, will inform the Challenge Pool.

#### b. Challenge Pool Eligibility:

PCMH+ PEs that do not improve year-over-year performance on the Avoidable ED Visits and Avoidable Hospitalizations quality measures will not be eligible to receive shared savings in the Challenge Pool.

Additionally, PCMH+ PEs that do not improve overall performance year-over-year on the Individual Savings Pool quality measures will not be eligible for the Challenge Pool. To determine eligibility, each PCMH+ PE's Individual Pool Quality Measures are averaged for the Prior Year and Performance Year, with each measure receiving equal weighting. Each PCMH+ PE whose Performance Year average is greater than the Prior Year average becomes eligible to participate in

the Challenge Pool.

c. **Challenge Pool Payment:**

A PCMH+ PE's Challenge Pool Payment will be determined by its Total Quality Score from the Individual Pool, their Challenge Pool Score and the number of member months in the Performance Year.

The Challenge Pool Score will be based on the PCMH+ PE's Performance Score and Improvement Score on a subset of four Challenge Pool quality measures selected by the PCMH+ PE from the list of all available Challenge Pool quality measures, listed in **Section III.F as Attachment I**. The selection of measures will be subject to DSS approval and must be made prior to the start of the Performance Year.

A PMCH+ PE's Challenge Pool quality score will be determined based on its Performance Score and Improvement Score as outlined below:

1. **Performance Score:**

Percentiles will be calculated for each PCMH+ PE relative to all PCMH+ PEs for each of the Challenge Pool quality measures for the Performance Year. One point will be earned for each Challenge Pool quality measure result above the 75<sup>th</sup> percentile of all PCMH+ PEs. These points will be summed to create the Performance Score.

<b>Quality Performance Measured Against All PEs as Percentile</b>	<b>Points Awarded</b>
Between 0.00% and 74.99%	0.00
75.00% or greater	1.00

For example, if a PE was above the 75<sup>th</sup> percentile in two of their four measures, its Performance Score would be two out of a possible four points.

2. **Improvement Score:**

Improvement will be calculated for each PE relative to their Prior Year score for each of the Challenge Pool quality measures. One point will be earned for improvement on each Challenge Pool quality measure result compared to the Prior Year score.

<b>Quality Improvement Measured Against Prior Year</b>	<b>Points Awarded</b>
No Improvement	0.00
Improvement	1.00

For example, if a PE earned higher quality scores in two measures in the

Performance Year compared to the Prior Year, and earned equal or lower quality scores in two measures in the Performance Year compared to the Prior Year, its Improvement Score would be two out of four possible points.

To calculate each PCMH+ PE's Challenge Pool Score, its points will be summed and then divided by the maximum number of points possible. The Challenge Pool Score, expressed as a percentage, will be used in calculating the portion of a PCMH+ PE's Challenge Pool shared savings payment.

Using the examples above, the PE's Challenge Pool Score would be its Performance Score (two) plus their Improvement Score (two) out of eight total possible points. The PCMH+ PE would receive a Challenge Pool Score of 50% (4/8 = .50).

Each PCMH+ PE will receive a portion of the challenge pool as a shared savings payment calculated using the following equation, which incorporates Challenge Pool Eligibility, the Challenge Pool Score, the Total Quality Score, and Performance Year MMs:

*PE Challenge Pool Allocation*

$$= \frac{\text{Total Quality Score} \times \text{Challenge Pool Score} \times \text{MMs}}{\sum_{\text{All PEs}} \text{Total Quality Score} \times \text{Challenge Pool Score} \times \text{MMs}}$$

A numerical example of the PCMH+ PE Challenge Pool Payment is provided below:

<b>Challenge Pool</b>	<b>All PEs</b>	<b>PE 1</b>	<b>PE 2</b>	<b>PE 3</b>	<b>PE 4</b>
Challenge Pool Funding (a)	\$500,000				
Challenge Pool Eligible (b) <sup>4</sup>		Yes	No	Yes	Yes
Total Quality Score (c)		35.00%	66.70%	80.00%	75.00%
Challenge Pool Score (d)		0.00%	50.00%	50.00%	100.00%
Performance Year Member Months (e)	325,000	55,000	130,000	100,000	40,000
Quality Adjusted MMs (if Challenge Pool Eligible) (f) = (c) x (d) x (e)	70,000	-	-	40,000	30,000
Challenge Pool Allocation (g) = (f) / ∑(f)	100.00%	0.00%	0.00%	57.14%	42.86%
<b>Challenge Pool Award (j) = (a) x (g)</b>	<b>\$500,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$285,714</b>	<b>\$214,286</b>

<sup>4</sup> Challenge Pool eligibility requires PCMH+ PEs to improve year-over-year performance on both the Avoidable ED Visits and Avoidable Hospitalizations quality measures. PCMH+ PEs must also improve overall performance year-over-year on the Individual Savings Pool quality measures.

## **8. Monitoring and Reporting**

PCMH+ practices must participate in the following monitoring and reporting Activities for PCMH+ W3. PCMH+ PEs must submit PE compliance reports to the Department, on a form provided by the Department, on a bi-monthly basis. These reports track various indicators of each PE's performance, including, but not limited to:

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

PCMH+ PEs may send group communications to Medicaid members regarding PCMH+. PCMH+ PEs are required to forward any such materials to DSS in advance of release to Medicaid members for DSS' review and approval.

PCMH+ PEs may be required to participate in desk reviews and on-site compliance reviews conducted by the Department. PEs must send DSS all requested materials for any desk review that is conducted, including, but not limited to: policies and procedures, PCMH+ reports and internal manuals. DSS may also conduct onsite compliance reviews to of RFP requirements, PCMH+ program requirements, any areas indicated through desk review or source, best/promising practices, and areas in which there is potential for improvement. Onsite reviews may include interviews with PCMH+ members, participants of Community Advisory Bodies, and PE staff members to gauge their opinions of the program. Onsite reviews may also include chart reviews to evaluate quality and completeness of members' clinical records.

## **9. Linkages with Community Partners to Address Social Determinants of Health**

In an effort to meaningfully address members' social determinants of health (SDoH), to integrate physical and behavioral health care, and to assist members in effective utilization of their Medicaid benefits, PCMH+ PEs must enter into relationships (whether contractual or informal) with local community partners.

Each PEs must also either sponsor a local community collaborative or participate in an existing collaborative for the purpose of foster understanding and partnerships among health providers and community resource agencies. A PE's Community Partnerships should 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 disorder 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 AN does not already include these entities); and
- Other State and local programs, both medical and non-medical.

#### **10. Screening for Social Determinants of Health (SDoH)**

PEs must implement the use of a nationally-recognized SDoH screening tool. The tool must be integrated into the PE's EHR and be accessible to all team members. PEs must develop workflows to ensure all PCMH+ members are screened at least annually or when the member experiences a significant change.

PEs are encouraged to use SDOH resources like 211 when addressing PCMH+ member needs. Established community information and referral services like 211 enable a critical connection between individuals and families in need and the appropriate community-based organizations and government agencies. PEs may utilize available resources, develop their own supports or work with other PEs to establish community connections for members in need.

#### **11. Electronic Health Record Access for Care Coordination**

Each PE must ensure seamless care coordination for PCMH+ members through the sharing of and access to all necessary electronic health record information needed to support the health, wellness, and care coordination of PCMH+ members. PEs must have a fully integrated electronic health record system that is accessible to all members of the care team employed by or under contract to the PE. If a PE does not have a single unified electronic health record system, PEs may utilize interoperability arrangements to enable seamless sharing of health information among different electronic health records systems.

At a minimum, PEs who utilize interoperability arrangements must have those arrangements in place prior to the start of Wave 3, be person-centered, protect patient privacy and security, comply with HIPAA and all other applicable federal and state requirements, and respect individual member preferences. PCMH+ PEs that utilize interoperability arrangements must ensure those systems offer access to information that supports seamless care coordination for PCMH+ members, have access to all necessary patient information across the multiple electronic health systems, and provide care coordinators access to the system to utilize the electronic health record to coordinate PCMH+ member care. Clinical care team members must be able to access and share a member's record to coordinate care and social determinants of care requirements throughout the PE, including across all provider entities and locations that are included in the PE.

**F. ATTACHMENTS:**

**I. PCMH+ QUALITY MEASURE SET**

<b>Scoring Measures</b>	<b>Measure Steward</b>	<b>National Quality Foundation #</b>
Avoidable Emergency Department (ED) visits <sup>5</sup>	3M	NA
Avoidable hospitalizations <sup>6</sup>	3M	NA
Adolescent well-care visits	OHSU	1448
Avoidance of antibiotic treatment in adults with acute bronchitis	NCQA	57
Developmental screening in the first three years of life	CMS	NA
Diabetes HbA1c Screening	NCQA	1799
Emergency Department (ED) Usage	AHRQ	NA
Medication management for people with asthma	NCQA	1517
PCMH CAHPS	NCQA	1392
<b>Challenge Measures<sup>7</sup></b>	<b>Measure Steward</b>	<b>National Quality Foundation #</b>
Behavioral Health Screening 1–17	DSS	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	2800
Readmissions within 30 Days	MMDN	NA
Anti-depressant medication management	NCQA	105
Prenatal and Postpartum Care (PPC)	NCQA	1517
Follow up after hospitalization for mental illness	NCQA	576
Follow up after ED visit for mental illness	NCQA	2605
<b>Reporting Only Measures</b>	<b>Measure Steward</b>	<b>National Quality Foundation #</b>
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	69
Asthma Medication Ratio	NCQA	1800
Breast cancer screening	NCQA	2372
Cervical cancer screening	NCQA	32
Chlamydia screening in women	NCQA	33
Diabetes eye exam	NCQA	55
Diabetes: medical attention for nephropathy	NCQA	62
Follow-up care for children prescribed ADHD medication	NCQA	108
Human Papillomavirus Vaccine (HPV) for Female Adolescents	NCQA	1959
Oral evaluation, dental services	ADA	2517
Use of imaging studies for low back pain	NCQA	52
Well-child visits in the third, fourth, fifth and sixth years of life	NCQA	1516

<sup>5</sup> Denotes measures on which improvement is required to be eligible for shared savings

<sup>6</sup> *Id.*

<sup>7</sup> The Challenge Pool Score will be based on a subset of four Challenge Pool quality measures selected by each PCMH+ PE from the list of all available Challenge Pool quality measures. The selection of measures will be subject to DSS approval and must be made prior to the start of the Performance Year.

**Abbreviations:**

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

## II. CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)<sup>8</sup>

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

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

#### Principal Standard:

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

#### Governance, Leadership, and Workforce:

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

#### Communication and Language Assistance:

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

#### Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and

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<sup>8</sup> <https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf>

evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

### **The Case for the Enhanced National CLAS Standards<sup>9</sup>**

*“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”*

*-Dr. Martin Luther King, Jr.*

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

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

The enhanced National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2011) and the National Stakeholder Strategy for

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<sup>9</sup> *Id.*

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.

### III. ADVANCED NETWORK (AN) PROVIDER FORM

**Name of AN Lead Entity:**

**Lead Entity TIN:**

Respondents that are AN Lead Entities are required to provide the following information in a separate Excel document. Please include information on all providers/provider practices as are necessary to describe the provider entities within the AN that are part of the Respondent's proposal to participate as part of the PCMH+ AN.

If any information does not correspond to the organizational chart, please explain any differences and/or where various providers fit within the organizational chart. DSS PCMH program participants must hold a Level 2 or 3 Patient-Centered Medical Home recognition from NCQA or an equivalent level of recognition from NCQA under its 2017 and any future standards. Only DSS PCMH approved practices may participate in PCMH+ W3.

For each provider/provider practice participating in the AN please include the following information in a separate Excel document:

- Name of the provider/provider practice
- Primary Address
- National Provider ID (NPI)
- Tax ID Number (TIN)
- Medicaid Provider ID
- PCMH Parent Name
- Site Name
- Site Address
- Number of Practices
- Number of Providers
- DSS PCMH Certification Approval Date
- NCQA Level
- Is the provider/practice a primary care practice or specialty?
- Is the provider/practice an independent entity or an affiliate, subsidiary, or division of another entity?
- Will this provider/practice be part of the PCMH+ network? Or will this provider/practice only work to assist and/or support PCMH+ providers/practices?

## **SECTION IV. PROPOSAL OUTLINE**

### **A. INTRODUCTION**

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

In some response sections the Department specifies a maximum number of pages for a response. The Department believes that this is a reasonable maximum number of pages and is intended to ensure that the response is focused on the requirements of this specific RFP. The stated maximum number of pages should not be used as a target or used to infer the relative importance of one section over another.

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### **B. PROPOSAL ORGANIZATION**

The proposal must be organized as specified below:

#### **I. ADMINISTRATIVE REQUIREMENTS**

##### **A. COVER SHEET**

See RFP Section I. D. 2 for information.

##### **B. TABLE OF CONTENTS**

See RFP Section I. D. 3 for information.

##### **C. CLAIM OF EXEMPTION FROM DISCLOSURE**

See RFP Section I. C. 11 for information.

##### **D. CONFLICT OF INTEREST - DISCLOSURE STATEMENT**

See RFP Section I. C. 12 for information.

##### **E. EXECUTIVE SUMMARY**

See RFP Section I. D. 4 for information. The proposer should provide a high-level summary of their proposal. This section should not exceed 2 pages.

## F. SUPPORTING DOCUMENTATION

- FQHC Supporting Documentation
- AN Lead Entity Supporting Documentation
- Acknowledgement Statements
- AN Confirmation
- FQHC Confirmation
- AN Provider Form
- Letters of Commitment
- Subcontractors' Profile
- Draft Subcontract(s)

## G. TERMS AND CONDITIONS DECLARATION:

The proposer should state that they can comply and are willing to enter into an agreement under the Terms and Conditions referenced by this RFP. Any proposed changes to the Terms and Conditions must be specific and described here for them to be considered during contract negotiations. The State will not accept broad or open-ended statements. It should be noted that if the State determines the proposed changes to be material, it can deem a proposal to be non-compliant and therefore not evaluate it further.

## H. FORMS:

- G.1 [Certification Regarding Lobbying](#)
- G.2 [Consulting Agreement Affidavit \(OPM Ethics Form 5\)](#)
- G.3 [Nondiscrimination Certification](#)
- G.4 [Gift and Campaign Contributions](#)
- G.5 [Iran Form](#)
- G.6 [Notification to Bidders, Part I-V \(CHRO\)](#)
- G.7 [Affirmation of Receipt of State Ethics Laws Summary](#)
- G.8 [Addendum Acknowledgement\(s\)](#)

An addendum acknowledgement form is included with each posted addendum.

## II. MAIN PROPOSAL.

### A. TECHNICAL PROPOSAL REQUIREMENT

**NOTEWORTHY:** Section III, PROGRAM INFORMATION, E. 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 PE's organization including:

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

(2) A description of the PE's organizational structure, 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 those other entities.

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

(b) **If the Respondent is an AN**, briefly describe the composition of the proposed AN including any other providers that will participate in the AN. Complete Section III. Program Information, F. Attachments, III. AN PROVIDER FORM, and include in **Section IV. Proposal Outline, B.I.F, Supporting Documentation – AN Provider Form** of your response. Submit signed letters of commitment or contracts (if available) for each provider the Respondent proposes to include in the AN and include as **Section IV. Proposal Outline, B.I.F, Supporting Documentation – Letters of Commitment** of your response. Upon participation in PCMH+ W3, the AN must provide copies of signed contracts and/or other applicable formal governing documents with each of the providers who are participating in the network. Provide an organizational chart that depicts all participants in the AN, including the AN Lead Entity.

**If the Respondent is an FQHC**, provide an organizational chart showing the existing or proposed structure of functions and positions by title within the FQHC's organization as it relates to PCMH+. Indicate which components of the structure are currently in place and which components are proposed to be created. Include a narrative summary of the proposed collaboration within the Respondent's organization related to PCMH+.

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+ W3.

**b. Respondent's Service Delivery System**

i. Describe the PE's service delivery system for all services provided to Medicaid members. For the PE in general and also, for ANs, for each provider entity in the AN,

describe the services that are provided, the number of Connecticut Medicaid members served, and the geographic area(s) that is served.

- ii. Governance: Describe the planned composition of the oversight body, how and in what timeframe the body will be formed and the planned functions and responsibilities of the oversight body, including how the PE will ensure that its governing board and/or other body will comply with the PCMH+W3 requirements for an oversight body as detailed in the RFP in SECTION I.D. PROPOSAL FORMAT 5. Minimum Qualification Requirements and SECTION III. F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 1. Organizational Requirements of PCMH+ PEs. **If the PE is an FQHC**, describe what aspects of the FQHC's U.S. Health Resources and Services Administration (HRSA) designation support the needs of members and enable the FQHC to fulfill PCMH+ requirements. Describe, the composition of, mission, and activities of the FQHC's board of directors and any other relevant committees or bodies affiliated with the FQHC.
- iii. **If the PE is an AN**, describe all applicable contracts or agreements among the various entities within the AN and explain: (1) how these contracts or agreements enable the AN to fulfill its mission, including coordinating care for individuals served by the AN; (2) how these documents meet the requirements described in SECTION III PROGRAM INFORMATION F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 3.Enhanced Care Coordination Activities; and (3) if applicable, how the AN plans to amend such contracts or agreements, or execute new contracts or agreements, in order to participate in PCMH+.
- iv. 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 membership in in the PE's oversight body, focus groups, surveys, community meetings, engagement with community partners, and/or other means, to be determined by the Respondent.
- v. Describe the planned role and functions of the senior leader and clinical director. Include the names and qualifications of the individuals who will occupy these positions, and explain to their capacity to effectively implement PCMH+.

**c. 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 relevant capacity and experience. **If the PE is an AN**, describe the strengths of any providers over and above the required PCMH practices that will be part of the AN.
- ii. Describe the Respondent's experience participating in any shared savings arrangements with government or private payers.

**d. 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. The following cannot serve as references: employees of DSS, the Respondent's current employees, officers, directors, or principals. 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 should be able to comment on the Respondent's capacity to implement PCMH+ Wave 3 program. 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, for PCMH+ PEs that are FQHCs, 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 members or similar populations, including the types of care coordination interventions utilized, 1 member participation, and a description of the outcomes that the Respondent has achieved. **If the PE is an AN**, provide this information for all providers that will participate in the AN.

### **b. Planned Approach**

- i. Describe how the Respondent will integrate behavioral health services and supports into existing operations, including sharing of behavioral health and physical health clinical documentation to ensure seamless and coordinated care.
- ii. Describe the how the Respondent will implement each of the required Enhanced Care Coordination Activities listed in SECTION III PROGRAM INFORMATION F. PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS. **If the PE is an FQHC**, also describe how the Respondent will implement each of the required Care Coordination Add-On Activities. Include specific details regarding the composition of the interdisciplinary team (with a focus on the role of the behavioral care coordinator), 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. Describe the Respondent's will minimum care coordinator education and experience requirements and comment on the Respondent's plans to use non-licensed staff, such as community health workers is desired.
- ii. Indicate which of the following three options the Respondent will implement and
  - (1) Employ a full time care coordinator dedicated solely to care coordination activities;
  - (2) Assign care coordination activities to multiple staff within a practice; or
  - (3) Contract with an external agency to work with the practice to provide care coordination.
- iii. Provide a detailed description of the Respondent's plan to provide care coordination services.

**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+ W3.

- i. Describe any existing community linkages that already enable the Respondent to comply with SECTION III PROGRAM INFORMATION PCMH+ PROGRAM DESCRIPTION & REQUIREMENTS 9. 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+ W3, 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+ W3.
  - (2) Describe the Respondent's approach to leveraging these partnerships to address social determinants of health for Medicaid members. Include any goals related to penetration rate and detail how the Respondent will ensure an effective feedback loop after referring member to community-based services.

### 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, **if the PE is an AN**, also the experience of any other provider in the AN, implementing quality improvement initiatives. For all PEs, 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 PCMH+ practices and their quality programs, and how these support any overarching organizational quality program. Describe the staffing and organizational structure, focus and means of assessing quality that is used by the Respondent and Also describe the means and frequency of all quality reporting conducted by the Respondent. Either provide a staffing chart or a narrative description of staffing of the quality program. Include the staff that are responsible 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 how the Respondent will monitor and improve the quality of services that are provided to PCMH+ Members.
- ii. Describe how the Respondent will utilize the provider profile reports provided by the medical ASO, 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.
- iii. Describe how the Respondent will prevent, monitor, and remedy under-utilization of clinically appropriate services. Further, explain how the Respondent's approach relates to the Respondent's quality initiatives.
- iv. Describe how the Respondent will identify and prevent panel manipulation.
- v. Describe how the Respondent will maximize opportunities for member engagement in PCMH+ care coordination activities.
- vi. Describe how the Respondent will m assist its eligible Medicaid members in maintaining continuous eligibility for Medicaid.

## **4. Data and Reporting**

A responsive proposal must include the following information about data and reporting.

Describe the Respondent's **existing and planned** capacity and methods of collecting, analyzing, and reporting on data, with a focus on health quality measures, population health, and continuous quality improvement.

## 5. Subcontractors

a. 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 [Subcontractor Profile](#) which is embedded in this section as a hyperlink, shall be included in **Section IV. Proposal Outline, B.I.F, Supporting Documentation – 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, B.I.F, Supporting Documentation - 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.

Selected Respondents shall be required to submit a copy of a final written agreement with each subcontractor prior to contract execution.

## B. FINANCIAL PROPOSAL

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

### 1. Financial Requirements

#### a. Accounting/Financial Reporting

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

#### b. Audited Financial Statements

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 all costs associated with PCMH+ activities, including staffing, fringe benefits, FTE, travel, supplies, potential vendor costs, contractual costs, direct/indirect costs, and support costs.
- ii. When identifying these costs, the Respondent must detail both existing sources of financial support for the above costs, and planned use of PCMH+ funds.

**d. Shared Savings Distribution**

A responsive proposal must include the following information about the Respondent's plans for distributing any shared savings payments that it receives.

- i. **If the PE is an AN**, describe how the Respondent will distribute shared savings payments among providers in the AN.
- ii. For all PEs, explain how the Respondent will ensure that the above distribution method will not 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 members 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.