REQUEST FOR PROPOSAL

for Medical Claims Administration and/or HealthCare Navigation (Advocacy) program services and/or clinical care/utilization management services, and/or Primary Care Initiative (PCI) program administration, and/or Municipal Employees Health Insurance Program (MEHIP) administration.

Released by Office of the State Comptroller on July 25, 2025

Questions due by 2:00pm ET Thursday August 7, 2025

Closing Date/Time: 2:00pm ET Friday September 26, 2025

State of Connecticut Medical Claims Administration, Member Advocacy, and PCI Administration Services RFP

In order to participate in this procurement, follow the process below:
Go to http://www.proposaltech.com/home/app.php/register. Enter your email address into the field provided. No registration code is necessary. Click "Begin Registration." If you already have an account with Proposal Tech it will be listed on the registration page, if you do not, you will be asked to provide company information. Once your account has been confirmed, check the appropriate box for the RFP you're registering for and click the "Register" button. An invitation will be mailed to you within fifteen minutes. If you have any questions regarding the registration process, contact Proposal Tech Support at 877-211-8316 x84.

1 Purpose/Introduction

1.1 **INTRODUCTION**

On behalf of the State of Connecticut (the "State"),the Office of the State Comptroller ("OSC"), in collaboration with the Health Care Cost Containment Committee ("HCCCC"), is soliciting proposals from vendors interested in providing Medical Claims Administration and/or HealthCare Navigation (Advocacy) program services and/or clinical care/utilization management services, and/or Primary Care Initiative (PCI) program administration, and/or Municipal Employees Health Insurance Program (MEHIP) administration.

There are approximately 67,000 active employees and non-Medicare retirees (151,000 members) covered by the State Plan which offers medical and prescription drug benefits. In addition to providing benefits to State employees and retirees, the State also covers employees in the probate court system, General Assembly members, former legislators, and other groups, as authorized by statute.

The State provides coverage under a Medicare Advantage and Prescription Drug (MA-PD)plan to an additional 63,000 Medicare retirees and Medicare- eligible spouses and dependents (services for this population are not covered in this offering).

The State also offers medical and prescription drug benefits to employees of certain municipal entities under the Connecticut Partnership Plan. There are approximately 29,000 employees (60,000 members) covered through the Partnership Plan who will also be included in this offering. A listing of these groups can be found here: https://www.osc.ct.gov/ctpartner/members.html

Through the issuance of this Request for Proposal (RFP), OSC is soliciting proposals from qualified bidders that can provide the services listed above. If you are interested and able to meet the requirements described in this RFP, OSC appreciates and welcomes your submission.

The State's vision is to contract with a vendor or vendors in a way that provides an exceptional member experience and utilizes innovation to create value, cost efficiency, and long-term sustainability for the plan. The State is interested in ensuring that vendor financial interests are aligned with the state's priorities (member experience, cost containment, and improvements in quality and outcomes) and are incorporated into meaningful performance guarantees as requested in this offering.

Vendors may submit proposals for one or all of these requested services.

OSC reserves the right to award any service in whole or in part, if proposals demonstrate that doing so would be in OSC's best interest. OSC also reserves the right to issue multiple awards, no award, cancel, or alter the procurement at any time. In addition, OSC reserves the right to extend the proposed RFP period, if needed.

Proposals containing the lowest cost will not necessarily be selected as OSC recognizes that factors other than costs are important to the ultimate selection of the provider or providers. Proposals provided in response to this RFP must comply with the submittal requirements set forth in later sections, including all forms and certifications, and will be evaluated in accordance with the criteria and procedures described herein. Based upon the results of the evaluation, the State Comptroller will award the contract(s) to the most advantageous Vendor(s), based on cost and the technical evaluation factors in the RFP. Any contract awarded hereunder shall be subject to the approval of the Office of the Attorney General in accordance with applicable state laws and regulations.

Please read the entire solicitation package and submit an offer in accordance with the instructions. All forms contained in the solicitation package must be completed in full and submitted along with the Technical Response and Price Proposal Worksheet, which combined, will constitute the offer. **This RFP and your response, including all subsequent documents provided during this RFP process will become part of the contract terms and policy between the parties.**

Entities responding to this RFP should also note that the State is requiring access to certain information and that this data must be provided to the State's health care consultant, Segal.

Submission of your proposal will acknowledge acceptance of these requirements. The financial requirements include initial and renewal pricing and projection controls.

OSC has retained Segal to assist in the evaluation of the proposals for responsiveness to the RFP and to review such proposals with them. Each proposal shall be evaluated in accordance with the factors listed in Section 1.2.6.

All Bidders must meet the General Proposal Conditions set forth in this RFP. Bidders are asked to respond only to the specific questions asked.

The State may also conduct multiple Best and Final "Reverse Auction" rounds during which each Bidder will be informed of its ranking in comparison to other Bidders in various financial and technical categories as may be selected by the RFP committee. The State reserves the right to eliminate the lowest ranked Bidder in each round.

Reverse auctions are authorized by Connecticut General Statutes ("C.G.S.") §4a-60b.

Proposals submitted in response to this RFP must comply with the requirements set forth in later sections, including all forms and certifications, and will be evaluated in accordance with the criteria and procedures described herein. The RFP process and any contract arising therefrom shall be governed in all respects by the laws of the State of Connecticut. Under no circumstances may a contract made with the State contain limited liability and/or binding arbitration provisions. The State may not waive its sovereign immunity or indemnify a Bidder.

2 General Information

2.1 **BACKGROUND**

The Comptroller is empowered by Connecticut General Statutes Section 5-259 to arrange and procure group hospitalization and medical and surgical insurance plans for State employees and retirees, including coverage for prescription drugs. The Healthcare Policy & Benefits Services Division (HPBSD) of the Office of the State Comptroller (OSC) administers these State healthcare coverage programs.

The HealthCare Cost Containment Committee (HCCCC) was established through collective bargaining in 1985 and is composed of six labor representatives and six management representatives. It is responsible for implementing cost control measures, monitoring and improving plan quality, and implementing health promotion and wellness activities for state employees, retirees, and their eligible dependents.

Under the State and Partnership Plans, medical benefits are administered by Anthem and Member Advocacy and Care Coordination services are provided by Quantum Health. The Pharmacy Benefits Manager is CVS Health. Dental benefits are administered by Cigna. Medicare retiree benefits (MA-PD) are administered by Aetna.

The State Plan also includes the following programs:

The Health Enhancement Plan

In 2011, in response to a collective bargaining agreement, the State implemented the Health Enhancement Program (HEP), a value-based insurance design ("VBID") program. The HEP program requires that all members enrolled in the plan (State employees, certain retirees, and their dependents as well as Partnership Group employees, certain Partnership retirees, and their dependents) complete age and gender appropriate preventive care and manage certain targeted chronic conditions. Upon initial medical benefit enrollment, employees are automatically enrolled in the HEP program unless they choose to opt out at that time. Employees and eligible retirees can change their HEP enrollment during the annual Open Enrollment period.

Participation in the HEP program requires all enrolled members to complete age and gender appropriate preventive services during the year (e.g. physical exam, cholesterol screening, well-woman exam, and one dental cleaning) and diagnosis screenings (e.g. colorectal cancer screening, Pap smears, and mammograms). In addition, persons with any of five specified chronic conditions, namely Diabetes Type I & II, Heart Failure/Heart Disease (Coronary Artery Disease), Asthma and COPD (Chronic Obstructive Pulmonary Disease), Hyperlipidemia (High Cholesterol), Hypertension (High Blood Pressure), must comply with educational requirements appropriate to the proper care of the condition.

The preventive visits are provided without charge to the member, and those with one or more of the specified conditions receive condition-related prescription drugs at reduced copays and will have copays waived for office visits related to those conditions.

Compliance in the program is measured on a calendar year basis with non-compliance penalties being implemented several months after the compliance year ends. Completed requirements are determined through claims data. Employees (and enrolled dependents) who do not comply with HEP requirements or who

choose to opt out of the HEP program have a $350 per person in-network annual deductible (up to a maximum of $1,400 per family) and pay an additional $100 more per month in employee share premium for medical and pharmacy coverage. Members who become non-compliant will be automatically reinstated to a compliant status once a claim for the missing service(s) is received. Presently, over 95% of employees participate in HEP. The program is administered by Quantum Health. Additional details about the program can be found on the HEP page on the state's benefits website CareCompass.

Providers of Distinction

This program, administered by Embold Health provides incentives to enrolled plan members (State of CT and Partnership employees, non-Medicare retirees, and their dependents (plan members) who are in need of certain health care services, such as: colonoscopy; spinal pain management, knee, and hip surgery, and then obtain such services from high quality, lower-cost providers identified through the program. This program was implemented as part of the 2017 Collective Bargaining Agreement (CBA). Additional detail about the program can be found on the Provider of Distinction page on the state's benefits website CareCompass.

Site of Service Program

The “Site of Service” program is for lab services is administered by the current medical carrier. Enrolled plan members have 100 percent coverage ($0 copay) for lab tests when they select a "Site of Service" (SOS) provider. SOSproviders are labs that provide high-quality, low-cost services. If a provider is in network but is not designated as a “Site of Service” provider, the member's cost share is 20%; members using out-of-network providers have a 40% member cost share.

Site of Care Program

The State of Connecticut has implemented a “Site of Care” (SoC) clinical review program to ensure that members aged 16 and older receiving targeted infusion therapies are treated in the most clinically appropriate and cost-effective settings. The program includes clinical reviews of infusion drugs and currently impacts approximately 472 members (335 State plan members and 147 Partnership plan members). Clinical reviewers assess provider-submitted documentation -including clinical notes, lab results, and standards-of-care criteria- to determine whether the current site of care is aligned with the member's clinical needs, health status, and cost-efficiency. Based on the outcomes, members and prescribers receive detailed communications and support through one of three review pathways: criteria met, criteria not met with alternative site guidance, or default approval when no feasible alternative exists. Pediatric patients under age 16 are exempt from the programs. There are no consequences to members not following the guidance provided.

Tiered PCP and Specialty Providers

The state plan currently has two tiers for PCP and Specialty provider copays. Preferred providers are PCPs with shared savings contracts with our present carrier. Preferred specialists are those with better than average quality and efficiency metrics.

Flyte Medical Weight Loss Program

The Flyte program is a clinically supervised medical weight loss program available to enrolled plan members, aged 18 and over who meet specific eligibility requirements. It is offered in partnership with Intellihealth and provides personalized treatment plans that may include nutritional counseling, behavioral therapy, and, where clinically appropriate, FDA-approved weight loss medications. Participants engage with licensed medical

professionals and health coaches through a virtual platform, with regular follow-up to support weight management goals. The program aims to improve chronic condition management, reduce the risk of developing weight-related illnesses, and support sustainable lifestyle changes. Eligible members may enroll directly, and those with qualifying conditions may be referred through the advocacy or care coordination programs. Additional information is available on the CareCompass Flyte page.

Hinge Health

Hinge Health is a digital musculoskeletal (MSK) care program offered to State employees, certain retirees, and their dependents experiencing back, joint, or muscle pain. The program provides a combination of exercise therapy, personalized care plans, wearable motion sensors, and 1:1 coaching from licensed physical therapists and health coaches. Members can access the program from home, with no out-of-pocket cost. Hinge Health helps prevent unnecessary surgeries and reduce chronic pain while improving member mobility and function. More information can be found on the CareCompass Hinge Health page.

Upswing Health

Upswing Health provides on-demand virtual orthopedic triage and support services to help members quickly assess and address musculoskeletal injuries or concerns. State employees, certain retirees, and their dependents can access board-certified orthopedic physicians and sports medicine experts for diagnosis, self-care recommendations, physical therapy referrals, or in-person care guidance. The service is designed to avoid unnecessary emergency room or specialist visits by offering high-quality remote consultations at no cost to members. Upswing also assists with navigating to high-value providers if further treatment is necessary. Program details are available on the CareCompass Upswing page.

Diabetes Prevention Program (DPP)

The Diabetes Prevention Program (DPP) is an evidence-based lifestyle change initiative available to eligible members at risk of developing Type 2 diabetes. This CDC-recognized program is delivered through virtual and in-person formats and includes coaching, dietary and fitness guidance, and group support. Participants meet regularly over the course of one year to establish healthy habits and achieve weight loss and physical activity goals. The program is offered at no cost to eligible members and is focused on long-term risk reduction. Enrollment information can be found on the DPP page of the CareCompass site.

Diabetes Management and Reversal Programs

The Diabetes Management Program, administered by Virta, provides a nutrition-first approach to managing and potentially reversing Type 2 diabetes. The program offers personalized support, continuous remote care, and a combination of nutritional ketosis to help users lose weight and reverse their diabetes. Virta's Diabetes Reversal Program helps achieve diabetes reversal by pairing nutritional therapy and medication adjustments with a physician-led care team. Enrollment information can be found on the Diabetes Resources page of the CareCompass site.

Firefighter Cancer Screening Program

In recognition of occupational health risks, the State Plan includes a specialized cancer screening program for eligible firefighters. This initiative provides access to advanced cancer screenings—such as low-dose CT scans or other diagnostic services—tailored to detect cancers commonly linked to firefighting, including lung, prostate, and gastrointestinal cancers. Screenings are covered in accordance with clinical guidelines and state program policy. Eligible firefighters may receive outreach through advocacy or care coordination teams to

ensure timely access to services. Additional information is available through CareCompass or by contacting the plan administrator, United Diagnostic Services

MEDICAL CLAIMS ADMINISTRATION

The State's medical benefits plans described below are defined through a collective bargaining agreement that remains in effect through June 2027. Bidders responding to this RFP must provide a proposal that duplicates the current benefit structure without modification for all plans however, bidders may offer an additional plan design that could replace or be offered alongside the Quality First Access Plan. Any such plan offerings should be a value-based insurance design which offers lower cost for high value services and providers and higher costs for lower value services and providers. Full details on the current plan designs, including medical plan summaries and plan documents can be found here.

Currently, the State offers all plan designs through Anthem BCBS. The plan design offered to Partnership groups is the State employee Expanded Access (POS) plan. The Quality First Select Access plan is available to Partnership 2.0 groups as a full replacement but as of today no group is enrolled. Details of the operating rules for the Partnership Plan can be found here: https://osc-static.ct.gov/ctpartner/index.html#info

Expanded Access Point of Service ("POS")

Within the POS option, each time medical services are required, employees elect whether to access a network provider (and are subject to coinsurance and benefit limits for some services) or access a non-network provider (and receive lower levels of plan benefits). Note that the POS plan provides open access to members and does NOT require a referral to access network specialists.

Standard Access Point of Enrollment ("POE") - This option operates as a typical "lock-in" Health Maintenance Organization ("HMO"). That is, benefits are only available if care is rendered by a network provider or authorized by the Health Plan. Note that the POE plans do NOT require a referral to access network specialists. The POE plan uses the same network that supports the State Blue Care POS plan.

Primary Care Select Access ("POE-PLUS") - This option operates as a typical "lock-in" Health Maintenance Organization ("HMO") with a gatekeeper. That is, benefits are only available if care is rendered by a network provider or authorized by the Health Plan. Note that the POE-Plus plans DO require a referral to access network specialists. The POE-Plus plan also uses the same network that supports State Blue Care POS plan.

Out-of-Area ("OOA") - This option is available to employees and retirees who permanently reside outside of the carrier's regional coverage area. The plan operates the same way as the Expanded Access “POS” Plan, where the member can access in or out-of-network services and does not have referral requirements. The difference is that the OOA plan currently utilizes BCBS's ("PPO") network which differs from the Blue Care network.

State Preferred- *This is a PPO option closed to new membership.* The plan operates the same way as the Expanded Access “POS” Plan, where the member can access in or out-of-network services and does not have referral requirements. The difference is that the State Preferred plan currently utilizes BCBS's PPO network which differs from the Blue Care network

The plans are available to active employees and non-Medicare eligible retired members. All medical plans are currently self-insured, and the State does not purchase any stop-loss coverage.

In addition to the options described above, the State also offers a high-quality innovation plan that is not collectively bargained:

Quality First Select Access- This is a tiered POS plan that uses the State Blue Care Prime Network, which is a smaller provider network focused in Connecticut, and only available to Connecticut residents.

Please note that it is not necessary to duplicate this plan design and OSC is interested in proposals for a Customized high-performance network for the non-bargained plan offering.

MEMBER ADVOCACY PROGRAM

OSC provides members a centralized point of information and engagement (Care Compass) through which they are able to access benefit information and guidance which includes:

- Finding participating providers, providers of distinction, site of service providers
- Resolution of claim and billing issues
- Making provider appointments
- Getting a second opinion
- Health Webinars and Blogs
- Single-sign-on benefits resource
- Education and guidance around the additional programs offered by the State
- HEP Compliance Status, news and reminders
- Benefits summaries and plan documents
- Administration of the Health Enhancement Plan (HEP) is also currently included within the Advocacy program. The program is administered by Quantum Health and is available to all State and Partnership employees, retirees (retired after 2011) and their families.
- Clinical Care Management, including UM, Prior authorization/pre-certification and HEP chronic disease education.

PRIMARY CARE INITIATIVE

The State of Connecticut has implemented a comprehensive Primary Care Initiative to enhance healthcare outcomes, improve care coordination, and ensure sustainable healthcare costs for state and Partnership Plan members. Established under **Executive Order No. 5 by Governor Ned Lamont in 2020** and codified into state law in June 2022, the initiative aims to increase primary care spending to 10% of total healthcare spending by 2025, with interim targets set at 6.9% in 2023 and 8.4% in 2024.

Participating provider groups are listed below:

Provider Group	Population Size	Hospital Based (Y/N)
Collaborative Health Solutions	4,698	N
CT Children's Care Network	12,603	Y
Day Kimball Medical Group	1,009	Y

Northeast Medical Group	14,323	Y
Privia Quality Network - CT Adult	10,433	N
Privia Quality Network - CT Pedi	9,541	N
ProHealth Physicians	18,132	N
Prospect Group	5,946	Y
SoNE	8,073	N
Stamford Health Medical Group	3,216	Y
Starling Physicians	6,204	N
University Physicians	7,157	Y
Value Care Alliance	5,209	Y
WCHN PHO	3,729	Y
Yale Medicine	3,023	Y
Aledade	*4948*	*N*
Trinity Health of New England	4086	*Y*

Financial Model

- **Enhanced Care Coordination Fee (CCF):** An additional **$12 per member per month (PMPM)** is added to the base CCF, subject to risk adjustment.
- **Risk Arrangement:**
  - Total Cost of Care (TCC) targets are defined with a **stop-loss threshold of $175,000** per member annually.
  - Three-year agreement terms with annual recalibration of TCC targets.
  - TCC targets exclude the State CCF in calculations and are adjusted annually based on predetermined trends: 5% for 2023, 4% for 2024, and 2.9% for 2025.
  - Risk adjustments accommodate significant changes in healthcare costs outside 4%-6% thresholds.
- Reconciliation of financial performance occurs annually, with shared savings or loss payments finalized by July following the close of the measurement year.
- Providers may opt for lump-sum settlements or installment payments over six months for any owed amounts.

MUNICIPAL EMPLOYEES HEALTH INSURANCE PROGRAM (MEHIP)

The State Comptroller is empowered by Connecticut General Statutes §§3-112 and 5-259 to procure the services of a third-party administrator for the Municipal Employees Health Insurance Program (MEHIP or the Program), which permits non-profits, municipalities, and small businesses to obtain healthcare and prescription benefit coverage at attractive rates. The program is fully insured. The program is currently providing health benefits for approximately 3,000 members, in 75 groups. A description of the Program may be found by visiting MEHIP - Municipal Employees Health Insurance Program - Office of the State Comptroller.

2.2 **OBJECTIVES**

Specific objectives related to each service category are listed below. A primary overarching objective of this RFP will be to align vendor financial incentives with the state's goals and priorities. To that end vendors for all scopes and services are asked to place a predetermined percentage of the administrative fees at risk for achieving the state's cost containment, member satisfaction and quality performance goals. Performance in each category that exceeds expectations will earn vendors upside financial bonuses. Further detail on this structure can be found in the performance guarantee section of this document.

1. **Medical Claims and Provider Network Administration**

- Ensure cost sustainability through efficient claims adjudication and network contracting
- Improve transparency in pricing, contracting, and utilization data
- Maintain a comprehensive, affordable, and high-quality provider network
- Provide flexible plan designs and tools to support effective benefit offerings
- Maintain a highly accurate provider lookup tool
- Implement value-based contracts, including site-of-service and specialty pharmacy arrangements
- Support medical pharmacy oversight, including:
    - Custom formulary administration
    - Manufacturer copay assistance integration
    - Customized preferred infusion networks
- Coordinate with all vendors (e.g., advocacy, pharmacy, PCI) for seamless member navigation
- Provide timely and accurate implementations for new Partnership groups and detailed disruption reports
- Facilitate advanced provider tools (e.g., PA, benefit, and claims data sharing)
- Deliver detailed reporting and analytics tools for OSC oversight
- Working with the Health Care Advocacy Provider, provide **collaborative, timely** response and resolution to escalated concerns brought forth by the advocacy provider or OSC
- Commit to performance guarantees, including:
    - Pricing, utilization, and data sharing
    - Provider and customer satisfaction
    - Mid-year network stability
    - Cost trends
    - Quality improvements

2. **Customer Service, Health Care Advocacy, and Health Enhancement Program (HEP) Administration**

- Deliver a seamless, high-touch customer service experience
    - High NPS and client satisfaction scores
    - Multichannel support (portal, call center, mobile)
- Provide real-time assistance with benefit navigation, provider referrals, and claims resolution
- Administer the Health Enhancement Program (HEP), including:
    - Preventive and chronic care compliance tracking
    - Personalized outreach and support
    - Real-time compliance and engagement reporting
- Coordinate with external vendors (e.g., Flyte, Hinge, Virta, Behavioral health)
    - Support a single sign-on, mobile-friendly member portal with customizable messaging and tools and real-time HEP compliance status
    - Align financial interests and incentives with the State's goals including cost control and quality improvements

- Provide timely and flexible responses to OSC's requests, adjustments and escalated concerns

3. **Primary Care Initiative (PCI) Administration**

- Align vendor incentives with **provider performance** on cost, quality, and satisfaction (NPS)
- Deliver **real-time financial and quality reporting to OSC and participating providers**
- Maintain monthly or more frequent:
  - Claims feeds
  - Pre-certification data
  - Attribution of high-risk and at-risk members
- Ensure all program reporting is **fully automated and integrated into population health tools accessible by OSC (de-identified) and participating provider groups** by **July 1, 2026**
- Provide a **comprehensive population health tool**:
  - Real-time updates
  - Pharmacy data integration
  - Race, ethnicity, and SDOH stratification
- Maintain **technical transparency**, including:
  - Annual release of financial and quality specifications 30 days before the start of the reconciliation period
  - Detailed shared methodology for financial and risk adjustment
- Enable **Connie HIE integration** and foster data innovation opportunities, (Connie information may be found here: https://www.conniect.org/)
- OSC **de-identified access** to reporting platform within 3 months of go live
- Staff the program fully by launch; provide timely replacements with OSC approval
- Support **structured collaboration**, including:
  - Biannual program review meetings
  - Rapid project scoping and pricing
  - Subject matter experts for analytics, reporting and program refinement

2.3 **Scope of Services Requested**

MEDICAL CLAIMS ADMINISTRATION

Note: Utilization Management Services will be awarded either as part of Medical Claims Administration or Member Advocacy.

Core Claims and Eligibility Administration

- Medical claims adjudication and payment integrity
- Eligibility file processing and sharing
- COBRA administration
- ESRD Medicare coordination
- Subrogation and recovery
- Out-of-network claims administration and savings programs
- Pre-adjudication audit capabilities
- Compliance with ACA and other regulatory reporting
- Development and distribution of plan documents, summaries, and custom ID cards

Provider Network Management

- Maintenance of a national provider network

- Transparent and effective provider contracting and relations
- Administration of a site of care program for select transfusions designed to direct care to the lowest intensity clinically appropriate site of care
- Accurate and timely updates to provider lookup tools
- Tiered network administration (PCPs and specialists)
- Support for direct contracting arrangements
- Administration of Site of Service (SOS) and other high-value care programs
- Implementation and management of value-based and episode-of-care contracting
- Customized high-performance network for non-bargained plan offerings
- Behavioral health network adequacy and access

Clinical Care and Population Health Services

- Utilization management and prior authorization
- Member education and engagement regarding treatment options
- Integration with PCI and other programs for coordinated care
- Identification and outreach for chronic conditions and high-risk member management
- Access to expert medical opinions and second opinions
- Treatment decision support and clinical guidance
- Virtual consultations and telephonic nurse line
- Complex case management
- Early identification and engagement for high-cost claimants
- Appeals management and medical necessity determinations
- Access to lab data and admission/discharge alerts (e.g., ADT feeds)
- Integration with third-party and digital point solutions
- HEP chronic condition management and education

MEMBER ADVOCACY AND HEALTH ENHANCEMENT PROGRAM ADMINISTRATION

Note: Utilization Management Services will be awarded either as part of Medical Claims Administration or Member Advocacy.

Member Services and Navigation

- Central call center with extended hours and escalation protocols
- Non-telephonic path for member assistance (i.e., live chat, AI-generated support)
- Assistance with benefits, claims, provider search, and appointment scheduling
- Customizable, mobile-friendly benefits portal branded “CareCompass”
- Integrated provider lookup tools and plan resources
- Secure single sign-on to access all vendor platforms
- Employer tools and editable messaging functions for OSC staff

Open Enrollment Support

- Online plan selection and enrollment system with integration to PeopleSoft
- Interactive decision support tools for members
- Staffing for virtual and in-person open enrollment events
- Call center staff training on open enrollment topics

Member Communications and Program Support

- Execution of ad hoc outreach campaigns and educational initiatives by postal mail and e-mail
- Administration of temporary or pilot programs as needed

- Coordination and referral to digital point solutions and third-party services

Health Enhancement Plan (HEP) Administration

- Claims-based tracking of preventive and chronic care identification and compliance
- Member self-monitoring tools (web/app) for HEP completion
- Direct provider outreach to confirm completed but unprocessed services
- Ongoing member education and engagement on HEP requirements
- Communications strategy including compliance reminders and penalty notifications
- Dedicated team of clinical and customer service professionals

Care Management and Clinical Services

(Same as Medical Claims scope above - offered under either contract)

- Chronic disease outreach and care coordination (especially HEP chronic condition members)
- Data sharing from providers, Connie, and lab sources
- Real-time member monitoring and support for ER or inpatient discharges
- Complex case management and nurse support line
- Appeals and prior authorization support
- Integration with PCI and Providers of Distinction programs
- Identification of care gaps, risk stratification, and patient navigation

PRIMARY CARE INITIATIVE (PCI) PROGRAM ADMINISTRATION

Program Administration and Operations

- Management of provider group contracts and reconciliation processes
- Engagement support (webinars, meetings, performance reviews)
- Seamless integration with other vendor partners (advocacy, point solutions, pharmacy, etc.)
- Maintenance of monthly attribution and provider panel updates
- Development of protocols for provider referrals to third-party services
- Full automation and integration of all program reporting by July 1, 2026

Reporting and Analytics

- Real-time quality and financial performance reporting
- Monthly claims data feeds (including third party pharmacy)
- Weekly or daily sharing of pre-certification data for attributed members
- Identification and outreach of high-risk and at-risk members
- Comprehensive population health tool with:
    - Access for providers and OSC
    - Integration of formulary and pricing data -Potential cost opportunities, utilizing alternative, high-value medications such as those reported by TDRX
    - Stratification by race, ethnicity, language, and SDOH
    - Incorporation of Providers of Distinction designations
- Benchmarked performance reporting (e.g., against book of business, cost growth targets, CT Office of Health Strategy benchmarks where available).
- Technical specifications for financial/quality targets are released 30 days before the start of the reconciliation period, giving provider groups advance notice of the coding/methodology of how quality is being measured.

Staffing and Technical Resources

- Dedicated clinical team for provider engagement and performance analysis

- Data analyst to support ad hoc and program reporting
- Project management resources to ensure timely delivery of program enhancements
- Dedicated contracting staff for provider agreements
- Allocation of hours and support from technical, economic, and IT teams as needed
- OSC approval of finalist candidates for key roles and replacement hiring within agreed timeframes

MUNICIPAL EMPLOYEES HEALTH INSURANCE PROGRAM (MEHIP)

The intent of this Request for Proposal ("RFP") is to obtain firm fixed price proposals from qualified vendors to perform the following services:

- Provide third party administration and record keeping services for the MEHIP;
- Develop and maintain a website for the MEHIP that contains information on the program, plans available and permits potential customers to obtain on-line rate quotes;
- Collect and account for all premiums collected and disburse funds to the appropriate health care carrier authorized to provide coverage through the Program;
- Develop professional marketing materials and maintain sufficient supplies to vigorously market the Program;
- Develop a strategic marketing plan that includes, attending marketing meetings, giving presentations to potential participants, outreach to business organizations, non-profit organizations, broker and trade groups;
- Respond to all quote inquiries from broker/client regarding quote, differences in plan designs, and MEHIP in general. Obtain clarifications from carrier and transmit to broker when census of data changes;
- When sold, verify rates with all parties, provide broker all relevant setup materials including MEHIP customized forms, plan summaries, SBC's, Business Associate Agreements between Administrator and group. Obtain printed material from carrier and distribute employee kits when requested. Answer all questions from group, broker or participants regarding plans and benefits.
- When requested, conduct on-site employee meetings for sold cases.
- Obtain signed installation documents, transmit to carrier, including checking enrollments for completeness, following up with group if not complete, securing binder check, completing communication sheet for the carrier and completing internal processes to enroll group.
- Update the billing system with the new group, plans and rates. Group can offer multiple plan options regardless of size.
- Update the billing system with enrollment data. Enter enrollment from paper forms when required by carrier or employer group.
- Act as liaison with the carrier during the entire installation process. Including printing temporary ID cards if carrier does not enroll group in a timely manner, contacting providers to confirm coverage, obtaining written benefit confirmations from carrier for scheduled procedures);
- Provide COBRA administration services;
- Provide account maintenance services.

2.4 **Evaluation of Proposals**

The State considers the following criteria to be the most critical (not listed in order of importance) in selecting a vendor to provide the services covered in the RFP. Finalists will be selected based on overall scores and or scores in categories related to specific services. In addition to the responses in the RFP, the committee will

also consider finalist interviews and BAFO responses, including responses to clarifying and follow-up questions in final scoring.

1. **General**

- Demonstration of Vendor's commitment to affirmative action by full compliance with the regulations of the Commission on Human Rights and Opportunities.
- Willingness to accept the terms and conditions of the State's proposed contract.
- Conformity with specifications.

2. **Medical Claims and Network Administration**

Claims Administration

- Efficiency of claims adjudication processes, including timely processing of claims.
- Effective and timely Coordination of Benefits (COB), including Medicare ESRD and subrogation claims.
- Administrative simplicity and the ability to bundle claim-related services.
- Commitment to complete pre-adjudication audits.
- Ability to administer current and future plan specific benefits and reimbursements if necessary

Network Strength and Provider Management

- Comprehensive national provider network that includes telehealth and behavioral health services.
- Ability and strategy to limit and manage immediate and future network disruption
- Vendor's ability to design, implement, and maintain customized networks focused on high-value providers.
- Ability to support direct contracting and limit adverse hospital contracts.
- Effective provider relations and credentialing.
- Provider tools, such as prior authorization portals and access to claims and benefit data.
- Accurate provider network roster, including accurate demographic data that is regularly updated and sharable with other state vendors as necessary
- Lookup tool for members with plan-specific features (may be contracted under Care navigation section as well).

Transparency, Data Sharing, Reporting, and Integration

- Ability to provide real-time or near-real-time claims visibility to the State.
- Willingness to provide transparent pricing, utilization data, and contract terms to the state.
- The ability to provide back-up claims data to validate billed bi-monthly claims invoices.
- Comprehensive analytics tools, dashboards, and regular reporting for plan oversight.
- Timely and structured data feeds to OSC and other designated State vendors.
- Data feeds to other vendors that support the state, including advocacy, pharmacy, and complex care integration vendors.
- Performance on key regulatory reports (e.g., RXDC, 1095, PCORI).
- The extent and clarity of cost transparency tools.
- Comprehensive reporting that includes billed charges, allowed amounts, discounts, member share, and net plan costs.
- Transparency in claim edits and adjudication system logic.
- Transparent provider contracts and tiering methodologies.

- Confirmation or disclosure of hidden fees (e.g. fees to TPA or related entities paid through claims, spread pricing, provider reimbursement that is higher than carrier fully insured book of business that in effect results in ASO business subsidizing lower provider rates for fully insured or other books of business).
- Detailed reporting, by data source (i.e. administrative claims, EMR/supplemental data, Connie statewide HIE (panel, Lab, ADT, CCD, etc.) on care quality metric data gap closure

Value-Based Contracting and Quality Performance

- Use of value-based arrangements and alternative payment models, including shared savings, bundled payments, alternate risk arrangements, episodes of care, reference pricing, and global budgets.
- Strength of medical pharmacy oversight strategies, including formulary, copay programs, and infusion networks.
- Experience and ability to support population health models (e.g., PCI, ACO, AHEAD).
- Willingness to align with OHS quality measures and quality improvement goals.
- Demonstrated ability and commitment to improve plan performance on OHS quality measures.

Member and Employer Group Services

- Plan administration functions including eligibility management, COBRA administration, billing, and Partnership group administration.
- Partnership group account management services including new group implementation, eligibility management and monthly billing.
- Comprehensive member support tools.
- Exemplary member satisfaction, performance history, and service standards as demonstrated by NPS or other available metrics.
- Account services and ability to establish and meet implementation and new program deadlines

Behavioral Health Integration

- Integrated network, claims, and UM administration.
- Commitment to mental health parity compliance and case management support.
- Seamless experience across medical and behavioral touchpoints.
- Commitment and ability to integrate and coordinate with OSC preferred behavioral health vendors and care navigation vendors (if applicable) to create a more seamless member experience.

Cost and Value Management

- Competitiveness of pricing as measured by the services offered relative to cost.
- Network discounts.
- Contracting strategy to manage future rate increases and service mix adjustments that increase costs beyond their relative value.
- Out-of-network claims savings programs and an effective single-case negotiation strategy.
- Comprehensive strategy to manage the total net cost of care and historical success in lowering total PMPM costs.
- Strategies to manage the cost of high-cost claimants through contracting.
- Commitment to place fees at risk for performance on the performance guarantees required in this RFP.

3. **Member Advocacy and HEP Administration**

Customer Service and Member Experience

- Quality of customer service based on Net Promoter Score (NPS), satisfaction metrics, and resolution efficiency.
- Real-time member assistance with benefit navigation, provider searches, scheduling appointments, and claim and billing issue resolution.
- Effective coordination with other plan vendors or providers to resolve issues.

Care Navigation and Innovation

- Ability to leverage technology to create positive and efficient member experiences.
- State-of-the-art digital platform with demonstrated ease of use for plan participants.
- Ability to apply plan-specific messaging, branding, and information.
- Record of designing and operating web-based and smartphone-based patient portals with plan specific interactive features and flexibility to meet plan specific needs.
- Ability to integrate all OSC health programs into a single platform through single sign-on capabilities.
- Quality of provider lookup tool with accurate demographic information, member cost shares, provider quality information, member ratings, and ability to incorporate plan incentives for the Provider of Distinction program, provider tiering, out of pocket cost estimates, including copay amounts, and feature point solutions as appropriate.

Health Enhancement Program (HEP) Administration

- HEP compliance monitoring and chronic condition stratification.
- Sufficiency and effectiveness of call center support.
- HEP member portal with real-time compliance tracking at the member and household level.
- Online access to HEP-targeted chronic condition education, clinical support, and member support.
- Outreach programs and support tools for chronic conditions, preventive care gaps, clinical care management, and member engagement.
- Demonstrated ability working with similar sized populations to administer plan-specific value-based insurance programs like HEP.
- Reporting capabilities specific to the HEP population including health outcomes, member engagement, the impact of HEP communications, and compliance status.
- Ability to customize reports and member communications to meet the State's specific requirements.
- Ability to make administrative adjustments required for changes in the program that may occur during the contract period.

Care Management

- The extent to which the clinical care management model addresses total population health, supports chronic and complex condition management, and integrates with Connecticut's Primary Care Initiative and value-based care frameworks.
- Range and clinical integration of chronic condition programs offered, including operational history, use of evidence-based protocols, and whether services are provided in-house or outsourced.
- Sophistication and frequency of tools and methodologies (e.g., predictive analytics, ADT feeds) used to identify members for care management and stratify them by risk level.

- The ability to demonstrate measurable outcomes, ROI, and engagement (with clear definitions of "active participation") from past or current implementations.
- Effectiveness of strategies to address health equity and social determinants of health, including the use of demographic data to inform and personalize care.
- The ability to ingest, utilize, and share key external data sources (e.g., EMR, CONNIE, pharmacy claims) and close data gaps to support care coordination.
- Quality of processes for coordinating with PCI-aligned primary care groups, including post-discharge care, care plan alignment, warm handoffs, and real-time data sharing.
- Willingness and ability to tailor workflows, engagement strategies, and care models to the specific needs of the State of Connecticut and its diverse populations.

Cost and Value Management

- Competitiveness of pricing as measured by the services offered relative to cost.
- Commitment to Performance Guarantees by placing administrative fees at risk.
- Demonstrated ability to increase member utilization of high-value providers
- Demonstrated ability of care management ability to lower plan costs, including in key areas like readmissions, ER visits and management of high-cost claimants

4. **Utilization Management**

Clinical Appropriateness & Evidence-Based Guidelines

- Use of nationally recognized clinical guidelines with the ability to align with state or plan-specific policies.
- Use of evidence-based care decisions.
- Periodic review process for clinical advances and technology updates.
- Site-of-care strategies to guide members to high-value, lower-cost care settings, including use of site-of-care analytics, provider contracting, and member outreach.
- Transparent and flexible oversight of specialty drugs under the medical benefit to leverage plan savings.
- Effective clinical review processes, site-of-care strategies, and cost-containment protocols.

Prior Authorization (PA), Medical Necessity Review and Appeals

- Efficient prior authorization process with automated approvals where appropriate.
- Clear process for medical necessity determinations, peer-to-peer reviews, and appeals.
- Appropriate clinical staff making determinations.
- Clear and timely communication with providers and members regarding adverse determinations and/or the need for additional information.
- Transparent and publicly available clinical criteria and the ability and willingness to share clear criteria with providers.
- The degree to which the vendor gets the determination right the first time, based on review of appeal turnover rates.

Integration with Claims and Advocacy Vendors

- Effective integration with claims processors, care management, disease management, and PBM vendors to ensure coordinated oversight.

- Flexibility to work with other vendors and manage your prior authorization processes to adjust to the state plan, even if it differs from your standard process.
- Transparent claim system coding, claim edits, and auto-adjudication measures.
- Real-time data exchange, custom reporting, and user-friendly dashboards. Commitment to disclose the use of predictive analytics and AI-driven decision support.
- Effective account and clinical team structure, escalation protocols, adherence to SLA standards, and reporting capabilities related to performance management.

Cost and Value Management

- Competitiveness of pricing as measured by the services offered relative to cost.
- Commitment to Performance Guarantees by placing administrative fees at risk.
- Ability to manage costs through effective prior authorization that limits member and provider disruption, while reducing utilization of low value or clinically inappropriate care.

5. **PCI Program Administration**

Program Administration

- Transparent incentives and risk-sharing arrangements around provider performance metrics, including cost efficiency, quality outcomes, and member satisfaction (e.g., Net Promoter Score).
- Ability to deliver financial and quality reporting in real-time or near real-time to providers and OSC.
- Efficient delivery of claims feeds, precertification data, and attribution files to provider groups
- Vendor's ability to allow provider access to data tools that provide effective and actionable insights to providers to help them manage population health. The data tool should include near real-time updates to claims and other data sources, pharmacy data integration (third party PBM data), and the ability to stratify by race, ethnicity, and social determinants of health (SDOH).
- Proposed staffing model and commitment to fulfill and maintain staffing model with well qualified and dedicated staff members.

Data Transparency

- Commitment from the vendor to fully automate unique PCI program reporting - including financial and quality metrics - and integrate it into population health tools accessible by OSC and participating providers no later than July 1, 2026.
- Demonstrated commitment to transparency through the annual release of financial and quality specifications, and a clear, detailed explanation of financial reconciliation and risk adjustment methodology.

Collaboration Readiness

- Willingness to participate in biannual program review meetings
- Ability to scope and price new projects within an agreed timeframe.
- Dedicated experts for analytics and program refinement.
- Capability and willingness to integrate with Connie HIE.
- Capability and willingness to ingest and integrate supplemental data.
- Commitment to data innovation projects that enhance care delivery and analytics.
- OSC access to the vendor's reporting platform

Cost and Value Management

- Competitiveness of pricing as measured by the services offered relative to cost.
- Commitment to Performance Guarantees by placing administrative fees at risk.
- Demonstrated ability to assist participating PCI providers in reducing total cost of care and improving quality.

6. **Municipal Employee Health Insurance Program (MEHIP)**

- Credentials and experience of firm and key personnel to be assigned to the project
- Demonstrated ability to meet and/or exceed all requirements
- Work plan and timeline for completion
- Cost of Services
- Overall quality and completeness of proposal (and interview if applicable)

2.5 Planned **Schedule of RFP Activities**

It is the State's intention to comply with the following schedule:

Date	**Activity**
July 25, 2025	Release RFP
July 29, 2025	NDA Deadline by 2:00 PM EDT
Week of August 4	Bidders' Conference
Aug 7, 2025	Vendor Question Deadline by 2:00 PM EDT
August 21, 2025	Vendor Questions Answered
September 26, 2025	Electronic Proposals Posted to Proposal Tech by 2:00 PM EDT
Week of November 3, 2025	Finalist Interviews (if Necessary)
November 7, 2025	Best and Final Offer, Round 1
November 24, 2025	Best and Final Offer, Round 2
December 12, 2025	Best and Final Offer, Round 3
January 5, 2026	Contract Awarded
January 12, 2026	Implementation Begins
July 1, 2026	Effective Date

- These dates represent a tentative schedule of events. The State reserves the right to modify these dates at any time, with appropriate notice to prospective bidders.
- This RFP does not commit the State to award a contract. The State reserves the right to reject all proposals, and at its discretion, may withdraw or amend this RFP at any time.
- The State may revise and amend the RFP prior to the due date for the proposal. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.
- The State reserves the right to reject any and all proposals received, for specific reasons, which include, but are not limited to, non-compliance with RFP requirements.

- Responses to this RFP will be the primary source of information used in the evaluation process. Each bidder is requested and advised to be as complete as possible in its response. The State reserves the right to contact any bidder to clarify any response or make a presentation.

2.6 **OTHER INFORMATION**

Other documents and information that may be helpful in preparing your proposal may be accessed online. Bidders are responsible for checking the OSC website for the most up to date information - https://carecompass.ct.gov/

3 Response Instructions

3.1 **INSTRUCTIONS FOR SUBMITTING OFFERS**

Detailed instructions for the completion and submission of your proposal will be found in the electronic RFP (eRFP) on ProposalTech. ProposalTech will be available to assist you with technical aspects of utilizing the system.

All sections of the eRFP must be answered completely and as outlined in the RFP, using ProposalTech.

Final submissions must be posted with ProposalTech at www.proposaltech.com no later than the due date and time cited. Access to the eRFP will be locked after that time. Bidders will not be able to post or change their responses. Late proposals will not be considered. OSC reserves the right to ask Bidders follow-up questions through ProposalTech as may be necessary to fully evaluate Bidder capabilities.

Please note that these instructions are to be read and followed by each Bidder and that failure to follow these instructions may result in rejection of a proposal offer for non-responsiveness or cancellation of contract if already awarded. **Any mention of "days" in this RFP will refer to calendar days unless noted otherwise.**

In order for your proposal to be considered and accepted, you must provide answers to the questions presented in this RFP. Each question must be answered specifically and in detail. Be sure to review this entire RFP before responding to any of the questions, so that you have a complete understanding of OSC's requirements with respect to the proposal.

1. Provide answers to all questions in your submission.
2. Provide an answer to each question even if the answer is "not applicable" or "unknown."
3. Answer the question as directly as possible.
    - If the question asks, "How many…", provide a number.
    - If the question asks, "Do you…", indicate Yes or No followed by any additional narrative explanation.
4. Where you desire to provide additional information to assist the reader in more fully understanding a response, refer the reader of your RFP response to your appendix/attachments. However, direct responses to all of the RFP questions must be provided and will be looked upon favorably.
5. Utilize the Proposal Tech's "Disclosure" tool to identify confidential answers or proprietary information you do not believe should be released if the State receives a request for your RFP submission under the State's Freedom of Information Act C.G.S. Sec. 1-200 et seq.
6. Bidder will be held accountable for accuracy/validity of all answers.

If your proposal is different in any way (whether more or less favorable) from what is requested in this RFP,

clearly indicate and explain the difference in the response to that particular question and the Bid Exceptions & Deviations Form - Attachment A. If you do not, the submission of your proposal will be deemed a certification that you will comply in every respect (including, but not limited to, coverage provided, funding method requested, benefit exclusions and limitations, underwriting provisions, etc.) with the requirements set forth in this RFP.

If you are unable to perform any required service, indicate clearly: a) what you are currently unable to do, and, b) what steps will be taken (if any) to meet the requirement, the timetable for that process and who will be responsible for the implementation, along with that person's qualifications.

All products should be priced individually. If pricing terms are provided for combining services, show the pricing terms as a separate line item.

Additional Invitation Request:

OSC recognizes that your firm may wish to provide a proposal both independently and with a "partner". If you'd like to submit more than one bid please reach out to Emily Peters (epeters@segalco.com) or Terry DeMattie (tdemattie@segalco.com) to request an additional invitation.

Non-Disclosure Agreement (NDA):

Upon logging into the ProposalTech system for this procurement, Segal will review its files for a current Global or Bid-Related NDA/Confidentiality Agreement. If there is an NDA/Confidentiality Agreement on file with Segal, Segal will send the data securely to the interested Bidder, as appropriate.

If there is no NDA/Confidentiality Agreement on file with Segal, an NDA document will be issued to the interested Bidder for signature. **Verbiage is non-negotiable.** Upon receipt of the newly signed NDA, or confirmation of an existing NDA on file, the data will be securely released to the Bidder via Segal's Secure File Transfer (SFT) system.

Secure data will not be released until a signed NDA between the Bidder and Segal is in place.

Bidder questions: Any questions regarding this RFP should be submitted directly via ProposalTech using the "Ask Questions" feature to Emily Peters, a Segal employee. Please submit your RFP related questions via ProposalTech to Segal no later than the date and time as specified in this RFP. Questions from any potential Bidder that is considering a response to this RFP will be answered. Questions sent via email or telephone will not be accepted. OSC reserves the right to provide a combined answer to similar questions. Any and all questions and answers to this RFP will be posted on ProposalTech and on State procurement websites.

Submission of proposals: Proposals are to be submitted electronically via the ProposalTech system by the specific due date and time. Proposals posted later than the time and date specified in this RFP will not be considered.

All decisions and evaluations will be determined from the proposals submitted electronically via ProposalTech.

Bidders shall also provide a **complete, electronic, redacted copy of your proposal including any attachments with your submission.**

Proprietary Items Exempt from Disclosure: Bidders must follow the ProposalTech system when responding to the RFP. If any items of this proposal are considered proprietary or confidential, Bidders must check the box

corresponding to that question's answer indicating it is exempt from disclosure. Failure to follow these directions will result in your responses being released as part of any open records request made in compliance with Connecticut state law.

The identification of confidential responses has been turned on for this RFP. If you feel that a response to a question contains proprietary/confidential information, click the "Disclosure" tab located underneath the question and check the box for "Exemption from Disclosure." Provide a reason for the exemption in the text field provided. If you do not provide a reason for exemption, the question will not be considered answered. If you have any questions regarding this process, please contact ProposalTech Support at 877-211-8316 x84.

Please also include redacted copies of any attachments that you post as part of your response.

Instructions for downloading a redacted proposal: Click on the **Standard** selection under the **Reports / Print** heading in the left-hand side menu. On the following screen check the box for an **External Report**. Under the filtered report options select **Flagged** and check the box under the **Exclude Marked** column for **Confidential**. Once those selections have been made click **Generate Report** and attach the redacted proposal here.

Confirm you have attached a copy of your redacted proposal submission.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

3.2 **QUESTIONNAIRE INSTRUCTIONS**

OSC and Segal will review and evaluate each proposal carefully. Many questions within the RFP system do not require lengthy responses. When a question does require a written response, please provide a response that is clear and concise. DO NOT answer any of the questions by referring to a prior answer or by referring to an attachment. Any such answers will not be considered and will constitute sufficient grounds for rejecting a proposal.

3.3 **PRE-BID CONFERENCE**

A pre-bid conference call will be held in connection with the RFP. The conference is tentatively scheduled for the week of August 4, 2025. A notice of this will be sent through Proposal Tech and Teams invitation to the Primary contact listed in Proposal Tech.

3.4 **RESTRICTION ON CONTACT WITH STATE PERSONNEL**

Except as called for in this RFP, from the date of release of this RFP until the right to negotiate a contract is awarded as a result of this RFP, any communications with personnel employed by the Comptroller's Office, members of the HCCCC, and RFP committee members about the RFP are prohibited until selection of the successor Bidder. All communications must be directed to Terry DeMattie and Emily Peters via ProposalTech. For violation of this provision, the State reserves the right to reject the proposal of the violator.

3.5 **CONFLICT OF INTEREST**

The Bidder shall certify in writing that no relationship exists between the Bidder and the State of Connecticut that interferes with fair competition or is a conflict of interest, and no relationship exists between the Bidder and another person or organization that constitutes a conflict of interest with respect to any State contract. Any successful Bidder must execute a contract and grant disclosure and certification form.

The Bidder shall provide assurances that it presently has no interest and shall not acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder. The Bidder shall also provide assurances that no person having any such known interests shall be employed during the performance of this contract.

3.6 **GOVERNING LAW**

The contract shall be governed in all respects by the laws of the State of Connecticut.

3.7 **VERIFICATION ACCURACY**

1. Your response must designate the individual responsible for coordinating proposal responses and for binding the company to the responses to this RFP.
2. Your response must designate the chief actuary or independent actuary retained by the Bidder who certifies the method used to determine and report requested information.

	Proposal Response Coordinator	Chief Actuary/Independent Actuary
Name	*20 words.*	*20 words.*
Phone #	*20 words.*	*20 words.*
Company	*20 words.*	N/A
Title	*20 words.*	*20 words.*
Email	*20 words.*	*20 words.*

3.8 **Product Selection**

Please select the services for which you will be submitting a bid. The applicable sections will be activated based on your response.

	Response
Medical Claims Administrative Services	*Single, Pull-down list.* 1: Yes, 2: No
Member Advocacy	*Single, Pull-down list.* 1: Yes, 2: No
Primary Care Initiative (PCI) Administration	*Single, Pull-down list.* 1: Yes, 2: No

Utilization Management (Utilization management services will be awarded with either the Medical TPA services or Member Advocacy services.)	*Single, Pull-down list.* 1: Yes, 2: No
Municipal Employee Health Insurance Plan (MEHIP) Administration	*Single, Pull-down list.* 1: Yes, 2: No

4 Proposal Requirements

4.1 **OSC General Terms and Conditions**

By submitting a proposal in response to this RFP, a bidder 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 OSC shall assume any liability for expenses incurred by a bidder in preparing, submitting, or clarifying any proposal submitted in response to this RFP.

3. **Exclusion of Taxes.** OSC is exempt from the payment of excise and sales taxes imposed by the federal government and the State. Bidders 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, OSC may request and authorize bidders to submit written clarification of their proposals, in a manner or format prescribed by OSC, and at the Bidder's expense.

6. **Supplemental Information.** Supplemental information will not be considered after the deadline submission of proposals, unless specifically requested by OSC. OSC may ask a bidder 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 OSC. At its sole discretion, OSC may limit the number of bidders invited to make such a demonstration, interview, or oral presentation and may limit the number of attendees per bidder.

7. **Presentation of Supporting Evidence.** If requested by OSC, a bidder 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. OSC may make onsite visits to an operational facility or facilities of a bidder to evaluate further the Bidder's capability to perform the duties required by this RFP. At its discretion, OSC may also check or contact any reference provided by the bidder.

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 OSC or confer any rights on any bidder unless and until a

contract is fully executed by the necessary parties. The contract document will represent the final agreement between the bidder and OSC 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 bidder or for payment of services under the terms of the contract until the successful bidder is notified that the contract has been accepted and approved by OSC and, if required, by the Office of the Attorney General.

9. **Acceptance or Rejection by the State**—The State reserves the right to accept or reject any or all proposals submitted for consideration. By responding to this RFP, applicants agree to accept the Comptroller's determinations as final.

10. **Conformance with State and Federal Law**—Any contract awarded as a result of this RFP must be in full conformance with statutory and regulatory requirements of the State of Connecticut and the federal government.

11. **Ownership of Proposals**— All proposals submitted in response to this RFP are to be the sole property of the State and will be subject to the applicable Freedom of Information provisions of C.G.S. §§1-200 et seq. In addition to the completed response, any bidder that submits matter that it in good faith determines to contain trade secrets or confidential commercial or financial information must mark such materials as “CONFIDENTIAL” and designate material through Proposal Tech's “Disclosure” tool.

12. **Ownership of Subsequent Products**—Any product, whether acceptable or unacceptable, developed under a contract award as a result of this RFP is to be the sole property of the State of Connecticut, unless explicitly stated otherwise in the RFP or contract.

13. **Communication Blackout Period**—Except as called for in this RFP, Contractors may not communicate about the RFP with any of the following: staff of the Healthcare Policy & Benefit Services Division within the OSC or members of the HCCCC until the successful bidder(s) are selected. No Contractor or Contractor's representative may contact an employee of the OSC or member of the HCCCC or their representatives and Bidder partners - Anthem, CVS Caremark, Upswing Health, Aetna, Cigna, Quantum Health, Hinge Health, Virta Health, and Intellihealth (Flyte)) regarding their proposal until final selections have been made. Until such time as final selections are made, any such contact will be considered collusion under the "Terms and Conditions" herein and may be grounds for disqualification of the Contractor's proposal.

14. **Availability of Work Papers**—All work papers and data used in the process of performing this project must be available for inspection by the State of Connecticut Auditors of Public Accounts for a period of three (3) years or until audited.

15. **Timing and Sequence**—All timing and sequence of events resulting from this RFP will ultimately be determined by the State. Late responses may or may not be considered, and it will be left to the Comptroller's discretion whether to accept or reject late responses.

16. **Stability of Proposed Prices**—Any price offerings from Contractors must be valid for a period of one hundred eighty (180) days from the due Date of the Contractor proposals.

17. **Oral Agreements**—Any alleged oral agreement or arrangement made by a Contractor with any agency or employee will be superseded by the written agreement.

18. **Amending or Canceling Requests**—The State reserves the right to amend or to cancel this RFP if such action is deemed to be in the best interest of the State.

19. **Rejection for Default or Misrepresentation**—The State reserves the right to reject the proposal of any Contractor that is in default of any prior contract or for misrepresentation.

20. **Rejection of Qualified Proposals**—Proposals are subject to rejection in whole or in part if they limit or modify any of the terms and conditions and/or specifications of the RFP.

21. **Collusion**—By responding to this RFP, the Contractor implicitly states that the proposal is not made in connection with any competing Contractor submitting a separate response to the RFP and is in all respects fair and without collusion or fraud. It is further implied that the Contractor did not participate in the RFP development process, had no knowledge of the specific contents of the RFP prior to its issuance, and that no employee of the agency participated directly or indirectly in the Contractor's proposal preparation.

22. **Conformance to Instructions**—All responses to the RFP must conform to the instructions herein. Failure to provide any required information, provide the required number of copies, meet deadlines, answer all questions, follow the required format, or failure to comply with any other requirements of this RFP may be considered appropriate cause for rejection of the response.

23. **Appearances**—In some cases, Contractors may be asked to appear (in person or virtually) to give demonstrations, interviews, presentations or further explanation to the RFP's screening committee.

24. **Standard Contract and Conditions**—The Contractor must accept the State's contract language and conditions. See Standard Contract and Conditions - Attachment B.

25. **Agreement**—The contract will represent the final agreement between the Contractor and the State and will supersede all prior negotiations, representations or agreements, alleged or made, between the parties. The State shall assume no liability for payment of services under the terms of the contract until the successful Contractor is notified that the contract has been accepted and approved by the Office of the State Comptroller and by the Office of the Attorney General, if required. The contract may only be amended by means of a written signed agreement by the Office of the State Comptroller, the Contractor, and the Office of the Attorney General, if required.

26. **Rights Reserved to the State**—the State reserves the right to award in part, to reject any and all proposals in whole or in part, to waive technical defects, irregularities and omissions if, in its judgment, the best interest of the State will be served.

27. **Receipt of Summary of State Ethics Laws.** The Contractor must acknowledge that is has received a summary of State Ethics Laws by submitting a signed receipt with its bid. See Attachments C and D hereto.

Contractors responding to this RFP must be willing to adhere to the following conditions and must affirmatively state their adherence to these requirements with a transmittal letter appended to their proposal response.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

4.2 **STANDARD CONTRACT, PARTS I AND II**

By submitting a proposal in response to this RFP, the Bidder implicitly agrees to comply with all applicable State and federal laws and regulations, including, but not limited to, those detailed in the State's "standard contract":

Part I of the standard contract will include the scope of services, contract performance, quality assurance, reports, terms of payment, budget, and other program-specific provisions.

Part II of the standard contract includes the mandatory terms and conditions required by state law, may be amended only in consultation with, and with the approval of, the Office of Policy and Management and the Attorney General's Office.

Note:

Included in the standard contract is the State Elections Enforcement Commission's ("SEEC") notice (pursuant to C.G.S. § 9-612(f)(2) advising executive branch State contractors and prospective State contractors of the ban on campaign contributions and solicitations. If a Bidder is awarded an opportunity to negotiate a contract with the State (OSC) 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 Bidder must inform the Bidder's principals of the contents of the SEEC notice.

4.3 **Additional Procurement Requirements**

The Connecticut Department of Administrative Services ("DAS") has implemented a requirement that all firms seeking to do business with the State must register their business on CTSource. The portal for registering a business is accessible at https://portal.ct.gov/das/ctsource/login?language=en_US

Firms will have the ability to view, verify and update their information by logging in to their CTSource account, prior to submitting responses to an RFP.

The guide to using CTSource appears at https://portal.ct.gov/das/-/media/das/ctsource/documents/ctsource-supplier-registration-portal-user-guide-final.pdf?rev=0ccb06cf4b2149bf913146e95afb9538
Additional required forms as described below must be submitted through CTSource by the deadline for submission of proposals. Paper or electronic copies need not be provided with the submission to the Comptroller's office. If you experience difficulty establishing your firm's account, please call DAS at 860-713-5095 or send an email to das.ctsource@ct.gov.

If you have difficulty accessing your CTSource account call 1-866-889-8533 or SupplierSupport@ProactisServiceDesk.com

4.4 **RIGHTS RESERVED TO THE STATE**

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

4.4.1. Timing Sequence. The timing and sequence of events associated with this RFP shall ultimately be determined by OSC.

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

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

4.4.4 Award and Rejection of Proposals. OSC reserves the right to award in part, 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. OSC may waive minor technical defects, irregularities, or omissions, if in its judgment the best interests of the State will be served. OSC reserves the right to reject the proposal of any bidder who submits a proposal after the submission date and time.

4.4.5. 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 awarded 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.

4.4.6. Contract Negotiation. OSC reserves the right to negotiate or contract for all or any portion of the services contained in this RFP. OSC further reserves the right to contract with one or more bidder for such services. After reviewing the scored criteria, OSC may seek Best and Final Offers (BAFO) on cost from bidders. OSC may set parameters on any BAFOs received.

4.4.7. Clerical Errors in Award. OSC reserves the right to correct inaccurate awards resulting from its clerical errors. This may include, in extreme circumstances, revoking the awarding of a contract already made to a bidder and subsequently awarding the contract to another bidder. 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 bidder is deemed to be void ab initio and of no effect as if no contract ever existed between the State and the bidder.

4.4.8. Key Personnel. OSC reserves the right to approve any additions, deletions, or changes in key personnel, with the exception of key personnel who have terminated employment. OSC also reserves the right to approve replacements for key personnel who have terminated employment. OSC further reserves the right to require the removal and replacement of any of the Bidder's key personnel who do not perform adequately, regardless of whether they were previously approved by OSC.

5 General Confirmations

Below are the specific confirmations for submitting a proposal. By checking “Confirmed”, Proposer represents the proposal submitted adheres to these confirmations, unless otherwise noted in the proposal. Failure to agree to any of these confirmations may result in disqualification of proposal. If Proposer takes exception to any of these confirmations, it must be so noted in the Bid Exceptions and Deviations Document (Attachment A) of their proposal response. These confirmations will also explicitly apply to any subcontractors used by the Proposer to deliver services to the State.

5.1 Bidder must be licensed to do business in the State of Connecticut.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

5.2 Bidder will notify the State and each affected individual directly if a breach of unsecured protected health information is discovered, as required under the Health Information Technology for Economic and Clinical Health ("HITECH") Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and in accordance with the HIPAA/HITECH Comprehensive Final Rule.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

5.3 Bidder will notify OSC when you first identify significant issues that cause member disruption.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

5.4 Bidder must agree that all data, records, files and other information relating to the plan belong to the State and are subject to release to the State if the contract is terminated.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.5 Bidder must provide detailed information on insurance, bonding, and guarantees offered in the event of issues caused by loss of operations due to an emergency or disaster.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.6 Please disclose offshore relationships, if any.

1000 words.

5.7 Bidder must receive prior approval for all communications to members. This includes all written website, electronic communication including, but not limited to, media advertising and regulatory mailings required under federal and/or state law. During open enrollment periods, all general media advertising in the State of Connecticut media markets must also be approved by the State. Failure to comply will result in a penalty payment of 0.50% of total expenses, no less than $30,000 and no greater than $100,000.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

6 GENERAL QUESTIONNAIRE - All Bidders

All proposals that will be considered must include responses to the following questions:

6.1 Organization, Legal Status and Ownership

6.1.1 State your organization's legal name, address and state of incorporation.

100 words.

6.1.2 How long has your organization been licensed to operate?

10 words.

6.1.3 Has your organization acquired, been acquired by, or merged with another organization in the past 24 months? If yes, please explain.

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

6.1.4 Is your organization anticipating restructuring or reorganizing in the next two years? (Include any major staff or office relocations or closings.)

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

6.1.5 Have you had a reportable or a reported event related to breaches of your systems and/or breaches where individual information has been compromised? If so, please explain what procedures were implemented to mitigate the risk of reoccurrence.

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

6.1.6 Are there any outstanding legal actions pending against your organization? If so, explain the nature and current status of the action(s).

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

6.1.7 Please provide references, including the names, addresses, email addresses and telephone numbers of three Public Sector clients that currently use your organization and for what service(s). If none, provide other references.

	Reference #1	Reference #2	Reference #3
Name	*50 words.*	*50 words.*	*50 words.*
Address	*50 words.*	*50 words.*	*50 words.*
Email	*50 words.*	*50 words.*	*50 words.*
Telephone	*50 words.*	*50 words.*	*50 words.*
Service/s	*50 words.*	*50 words.*	*50 words.*

Number of members	*Integer.*	*Integer.*	*Integer.*

6.1.8 Please provide three references of clients that recently terminated their contracts with your organization.

	Reference #1	Reference #2	Reference #3
Name	*50 words.*	*50 words.*	*50 words.*
Address	*50 words.*	*50 words.*	*50 words.*
Email	*50 words.*	*50 words.*	*50 words.*
Telephone	*50 words.*	*50 words.*	*50 words.*

6.1.9 Will you use any subcontractors for this engagement?

Single, Radio group.
1: Yes, please list [500 words] ,
2: No

6.1.10 What is the name and title, telephone number, e-mail address and postal address of the contact person for this RFP?

100 words.

6.1.11 Does your firm partner with one or more Private Equity firms as a source of funding?

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

6.1.12 Confirm you will provide the last 2 years of your firm's unaudited financial statements.

Single, Pull-down list.
1: Confirmed and unaudited financial statements attached,
2: Not Confirmed

6.2 Implementation

6.2.1 The anticipated effective date is July 1, 2026. Please provide an implementation plan that includes both a project overview and details on specific tasks, timeliness, and responsibilities for each of the services on which you are bidding.

Single, Radio group.
1: Attached,
2: Not provided

6.2.2 Are there any specific reporting or administrative procedures you would require of the State prior to implementation of your program?

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

6.2.3 Please describe the biggest implementation risk and how risks will be mitigated.

500 words.

6.2.4 Please complete the following table regarding implementation allowance/credits.

	Response
Please state any implementation allowance/credit that will be allocated to the Plan.	*200 words.*
What services can the implementation allowance/credit be used for?	*500 words.*
Would the State be able to use the implementation allowance/credit for services such as communications and contract review?	*Compound, Pull-down list.* 1: Yes, 2: No, please explain: [200 words]

6.2.5 Will an implementation manager be assigned to lead and coordinate the implementation activities with the State?

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

6.2.6 Describe the resources and the estimated number of hours, both total and per week, which will be needed from the State to support and manage the implementation.

500 words.

6.2.7 What type of custom branded communications materials and support do you provide with respect to onboarding and throughout the program? Is there an additional cost?

500 words.

6.3 Account Management

6.3.1 Provide the address of the principal office that will provide services to OSC.

50 words.

6.3.2 Please identify the designated account representative(s) available to respond to questions from the State. Please include a brief professional biography of these individuals.

	Account Representative #1	Account Representative #2	Account Representative #3

How long has this person been with your organization?	*10 words.*	*10 words.* Nothing required	*10 words.* Nothing required
How many years of relevant experience does this person have?	*Decimal.*	*Decimal.* N/A OK.	*Decimal.* N/A OK.
What experiences do they have working with public sector clients?	*500 words.*	*500 words.* Nothing required	*500 words.* Nothing required
How many clients will the account manager be responsible for?	*Integer.*	*Integer.* N/A OK.	*Integer.* N/A OK.

6.3.3 Describe how you monitor and measure customer satisfaction and quality assurance.

500 words.

6.3.4 Has your organization had an SAS-70 audit conducted recently? Please provide a report.

Single, Radio group.
1: Yes, report attached,
2: No, explain: [200 words]

6.3.5 Provide an overview of how the OSC relationship will be managed, both strategically and on a day-to-day basis.

500 words.

6.4 HIPAA and Data Security Compliance

6.4.1 Please complete the following table regarding HIPAA EDI, Privacy, and Security.

	Response
Describe the process used by your company to comply with HIPAA EDI, Privacy, and Security requirements.	*500 words.*
Have you received external or independent certification regarding your HIPAA compliance?	*Compound, Pull-down list.* 1: Yes, please explain: [200 words], 2: No

6.4.2 Who is the key individual in your organization responsible for compliance with the HIPAA Administrative Simplification provisions? Please identify that individual by name and title.

50 words.

6.4.3 Describe your HIPAA EDI compliance solution relative to providing eligibility data to vendors.

500 words.

6.4.4 Is your staff trained on all Privacy and Security requirements? Describe your training program and enforcement policy.

Single, Radio group.
1: Yes, describe: [500 words] ,
2: No, explain: [500 words]

6.4.5 Does your system produce sufficient audit trails to satisfy the HIPAA Privacy and Security regulations?

Single, Radio group.
1: Yes, explain: [500 words] ,
2: No, explain: [500 words]

6.4.6 How is security set up in the system? What are the different levels of security?

500 words.

6.4.7 Is your system database encrypted?

Single, Radio group.
1: Yes, explain: [500 words] ,
2: No, explain: [500 words]

6.4.8 Are system data backups encrypted?

Single, Radio group.
1: Yes, explain: [500 words] ,
2: No, explain: [500 words]

6.4.9 Are all electronic transmissions of PHI, including eligibility files, authorizations, reports, etc., encrypted or sent via secure means?

Single, Radio group.
1: : Yes, please explain: [200 words] ,
2: No, please explain: [200 words]

6.4.10 Which encryption methods do you support for e-mails and file transmissions? Please describe.

500 words.

6.4.11 Are all electronic transmissions of PHI, including eligibility files, authorizations, reports, etc., encrypted or sent via secure means? Which encryption methods do you support for e-mails and file transmissions? Please describe.

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No

6.4.12 What are your procedures for data destruction prior to hardware and media disposal?

500 words.

6.4.13 Please complete the following table regarding EDI transactions.

	Response
Which EDI Transactions sets have you implemented and for those remaining, what is the target implementation date?	*500 words.*
If you plan to outsource to an outside entity, who will be that business partner?	*200 words.*

6.4.14 Have you had a HIPAA violation in the past three years? If yes, please describe what procedures are implemented to mitigate the risk of reoccurrence.

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

7 QUESTIONNAIRE - Medical Claims Administration

7.1 EXPERIENCE

7.1.1 Provide statistics regarding membership that receives medical administration services from your firm. Provide statistics further split as requested in the grid, below.

	Total Group Covered Lives	Group Covered Lives in Connecticut	Total Number of Employer Groups	Public Sector Covered Lives	Number of Public Sector Groups	Number of Clients with 50,000+ Covered Lives
2024	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*
2025	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*

7.1.2 How many new groups with more than 5,000 covered lives did your organization add effective on or after January 1, 2025 to date?

	2025 New Groups	**Total Member Count**
Actives and Early Retirees	*Integer.*	*Integer.*

7.1.3 What percentage of your 2024 total group membership renewed for the 2025 plan year to date?

	2024 Total Group Member Percentage Renewed
Actives and Early Retirees	*Percent.*

7.1.4 The State currently offers health advocacy and navigation services through a separate concierge service vendor. Should the state choose to retain a carve out model, please describe how you would collaborate with them to achieve best practices in client services and data integration.

500 words.

7.1.5 Do you have a dedicated claims support team? If so, describe your process for handling claim inquiries. What are your service level agreements for responding to claims inquiries and processing corrections? Please include turnaround time.

500 words.

7.1.6 Do you allow the advocacy vendor services leads to have defined authority to override claim denials or errors within agreed-upon guidelines or contractual rules? Please explain this process and scope of authority.

500 words.

7.1.7 Provide examples of your collaboration with advocacy vendors or care management partners to resolve complex claim issues.

500 words.

7.1.8 Are you willing to delegate all utilization management responsibilities, including J-code authorizations to a designated care management or advocacy vendor?

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

7.1.9 Describe how your organization ensures a collaborative relationship with care management/advocacy vendors. What practices do you follow to promote a shared commitment to member satisfaction?

1000 words.

7.1.10 Describe the pricing transparency tools and data you make available to the care management vendor.

1000 words.

7.1.11 Do you provide daily eligibility files to the care management provider? Confirm your ability to support HIPAA 834 format or a mutually agreed-upon layout.

Single, Radio group.
1: Yes confirmed,
2: No, please explain: [500 words]

7.1.12 How do you accommodate custom eligibility code translation for care management or advocacy vendors? Do you provide daily or otherwise agreed frequency of complete claims files to the care management provider.

500 words.

7.1.13 Confirm that your claims data includes: Complete claim lifecycle details; Billed/charged, plan paid, and member paid amounts; Identifiable member and provider information; Clinical and supplemental data to support member management and reporting.

Single, Radio group.
1: Confirmed,
2: Not confirmed, please explain: [500 words]

7.1.14 Are you able to ingest daily authorization files from the care management provider? Describe the formats supported and data reconciliation protocols.

500 words.

7.1.15 Do you provide API access to Explanation of Benefits (EOBs) and member ID cards? Confirm whether these APIs return PDF images suitable for display on external portals and internal systems.

500 words.

7.1.16 How do you provide member-level accumulator information (i.e., combined deductible/OOP tracking for medical and pharmacy)? Is this shared via API or daily file transfer?

500 words.

7.1.17 Will you grant the care management vendor view-only access to your payer portal for eligibility and claims look-up? If so, what safeguards and access controls are used to protect client data while allowing this access?

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No, please explain: [500 words]

7.1.18 Do you provide the care management vendor with direct access to an account management team for escalations? If so, describe your escalation protocol including timelines, triage levels, and leadership involvement.

Single, Radio group.
1: Yes, please describe: [500 words] ,
2: No, please explain: [500 words]

7.1.19 Describe any issues or challenges you've experienced in working with an outside concierge service vendor and how you would propose solving for such issues related to this engagement.

1000 words.

7.2 ELIGIBILITY

7.2.1 Bidder must agree to accept and provide electronic data feeds in the appropriate HIPAA or State defined format on a schedule determined by the State. Currently retiree enrollment data is sent via the HIPAA 834 format. All carriers will receive the identical format and data structure as defined by the State.

Single, Radio group.
1: Confirmed,
2: Not confirmed, please explain: [500 words]

7.2.2 Confirm that you will update eligibility data within 24 hours from receipt of data for the State Plan and the Partnership Plan.

Single, Radio group.
1: Confirmed,
2: Not confirmed, please explain: [500 words]

7.2.3 Confirm that you will provide direct same day email confirmation that the eligibility file was received, properly loaded, processed, and that this confirmation will include the date of receipt for the State Plan and the Partnership Plan.

Single, Radio group.
1: Confirmed,
2: Not confirmed, please explain: [500 words]

7.2.4 Confirm you will post remaining data, not identified as errant, within 24 hours, for the State Plan and the Partnership Plan.

Single, Pull-down list.
1: Confirmed,
2: Not Confirmed

7.2.5 Confirm you will provide the State with online access to their enrollment information, for the State Plan and the Partnership Plan, in real time.

Single, Pull-down list.
1: Confirmed,
2: Not Confirmed

7.2.6 Confirm that you will send eligibility to the State's PBM (Caremark) nightly.

Single, Radio group.
1: Yes, please explain: [Unlimited] ,
2: No

7.2.7 Confirm that you will send eligibility files to any state-contracted vendors within the time frames necessary to administer their contracted benefits as the state requests.

Single, Radio group.
1: Yes, please explain: [Unlimited] ,
2: No

7.2.8 **FILE EXCHANGE PROTOCOL**

There are currently two methods for exchanging files with the State's Core-CT system:

1. The Bidder logs into the secure Core-CT Production Supplier Portal via https to download files. The URL is https://coreps.ct.gov/psp/PSPRD/?cmd=login
   -or-
2. The Bidder logs into the secure Core-CT SFTP Server. The URL is https://sfile.ct.gov/ . For those using an automated system SFTP is secure and can be setup for automation.

Testing Requirements

At least one test cycle must be completed successfully prior to going live employing one of the previously mentioned file transports.

The Core-CT Supplier Portal uses a non-standard port (10400 for Production, 15000 for Test) and that may require action by the carrier's Tech Support area to accomplish this. Bidders must report in their response to this RFP whether they were able to successfully reach the portal sign on page at: https://coreps.ct.gov/psp/PSPRD/?cmd=login or have successfully connected to: https://sft.ct.gov/

For testing purposes, the link to the TEST supplier portal is: https://corepstprs.ct.gov/psp/PSTPRS/?cmd=login&languageCd=ENG&

Additional information for all parties that exchange data with State's Core-CT system is available at: http://www.core-ct.state.ct.us/hrint/

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

7.2.9 Complete the table below regarding ID Cards:

	Response
a. Confirm that you will issue a member ID card and mail, via surface mail, to covered Members within ten (10) business days following the enrollment period.	*Compound, Pull-down list.* 1: Confirmed, explain: [500 words], 2: Not confirmed, explain: [500 words]
b. Confirm that all State covered members will have a valid ID card in hand prior to July 1, 2026.	*Compound, Pull-down list.* 1: Confirmed, explain: [500 words], 2: Not confirmed, explain: [500 words]
c. Confirm that you will re-issue the member ID card within five (5) business days of notification that a member has lost a card, or for any reason that results in a change to the information disclosed on the member ID card.	*Compound, Pull-down list.* 1: Confirmed, explain: [500 words], 2: Not confirmed, explain: [500 words]
d. Confirm extra ID cards will be available for a dependent child away from home attending school or residing out of area.	*Compound, Pull-down list.* 1: Confirmed, explain: [500 words], 2: Not confirmed, explain: [500 words]
e. Describe how ID cards will be requested and shared with a third party advocacy vendor, should the state choose to continue to carve out this service.	*500 words.*
f. Indicate how many ID cards you will mail to subscribers with family coverage, at no additional charge.	*500 words.*

7.2.10 Do you have available resources to help manage open enrollment? The state may be interested in leveraging a third-party open enrollment portal, do you offer or have a partnership that offers open enrollment and new employee self-service portals? If so please describe.

1000 words.

7.3 CLAIMS PROCESSING

7.3.1 Describe your ability and process for pre-adjudication auditing.

200 words.

7.3.2 What safeguards are in place to monitor quality (including retrospective claims reviews) and HIPAA compliance for staff who work from home?

200 words.

7.3.3 How are claims, customer service, utilization review and case management systems linked? And how can necessary data and information be shared with a third-party advocacy vendor if required?

Single, Radio group.

1: Same system,
2: Integrated, but different systems,
3: Different systems, but accessible to all,
4: Not linked,
5: Some linked,
6: Other, please specify: [500 words] ,
7: N/A

7.3.4 Does your claims system have the capability to automatically match claims with utilization management information both in- and out-of-network?

Single, Pull-down list.

1: Yes,
2: No,
3: N/A

7.3.5 Please complete the following table regarding auto adjudicated claims:

What percentage of total claims are auto adjudicated for your national Book of Business?	*Percent.*
What percentage of total claims are auto adjudicated for your State of Connecticut Book of Business?	*Percent.*

7.3.6 Does your claims system have the capability to process network, non-network, out of State or regional claims on the same system?

Single, Pull-down list.
1: Yes,
2: No

7.3.7 Describe your process to review claims for billing irregularities by provider (such as regular overcharging, unbundling of procedures, upcoding or billing for inappropriate care for stated diagnosis, etc.).Are such reviews performed prior to claims payment or retrospectively? For prospective reviews, are all claims prospectively reviewed or a subset? If a subset please provide details.

500 words.

7.3.8 How are claims selected for internal audit? What triggers do you utilize?

Multi, Checkboxes.
1: Random by system,
2: Set percent per day,
3: Set number per approver per day/week,
4: Diagnosis,
5: Dollar amount,
6: Other, please specify: [500 words]

7.3.9 On average, what percentage of all claims are audited by an internal audit group?

Percent.

7.3.10 What are your procedures for recovery of overpayments or duplicate payments? How do those procedures differ for in-network vs. out-of-network providers? What procedures do you have in place to avoid duplicate payments and overpayments in the first place, including claims that require some manual intervention?

1000 words.

7.3.11 What are your procedures for recovery of overpayments on claims that require subrogation?

1000 words.

7.3.12 How do you screen for and identify claims that could be the responsibility of a third-party? Please explain your process in detail, including details on any subcontractors or vendors your organization uses to research and/or recoup.

1000 words.

7.3.13 Confirm you agree to return 100% of all recovered monies from overpayments, duplicate payments, and overpayments on third-party liability or subrogation claims, or other processing errors to the State, without a processing fee?

Single, Pull-down list.
1: Confirmed,
2: Not Confirmed

7.3.14 Describe your process for claim coding audits. How often and what percentage of claims are audited for proper claim coding?

1000 words.

7.3.15 Do you agree to hold the State harmless for any liability arising from your firm's payment processing errors that result in overpayment or duplication of payments to providers?

Single, Radio group.
1: Yes,
2: No, please explain [500 words]

7.3.16 Are your eligibility and claim systems compliant with current HIPAA regulations?

Single, Pull-down list.
1: Yes,
2: No

7.3.17 Confirm that you will review and process all waivers related to the ER copay and Site of Service program. The vendor will notify members of the determination and provide monthly reporting.

Single, Pull-down list.
1: Confirmed,
2: Not Confirmed.

7.3.18 Are claims processed and reviewed for inappropriate billing, similar to your fully-insured book of business, with the exception of plan-specific edits and benefit coverage requirements? If not, how do they differ?

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

7.4 COORDINATION OF BENEFITS (COB)

7.4.1 Explain how your system:
a. Identifies the existence of other insurance (e.g., from your book of business, another employer, workers compensation or motor vehicle insurance);
b. Questions/tracks COB;
c. Handles COB conflicts;
d. Communicates with members and providers;
e. Interfaces with other group carriers regarding COB;
f. Monitors Medicare eligibility and enrollment.

1000 words.

7.4.2 When you are the secondary payer in a COB situation, do you use your usual, customary, and reasonable (UCR) profiles, reduced network fees, or those of the primary carrier in determining your level of reimbursement?

1000 words.

7.4.3 How is the State held harmless for erroneous payments made by you during the COB process?

1000 words.

7.4.4 Please complete the following table:

Average COB savings as a percent of total plan	*Percent.*
Will you guarantee COB savings?	*Single, Pull-down list.* 1: Yes, 2: No

7.4.5 Confirm you will provide a monthly subrogation report specific to the State. Provide a sample of the monthly reporting that will be provided to the State.

Single, Radio group.
1: Confirmed with monthly subrogation report attached, explain: [500 words] ,
2: Not Confirmed

7.4.6 Confirm that when spouses are both employees of the State and enrolled in the plan there will not be a coordination of benefits with the plan.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, explain: [500 words]

7.5 COBRA

7.5.1 COBRA services must be included. ASO Administrative Fees should include pricing for COBRA services. Confirm your agreement with this provision.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, explain: [500 words]

7.5.2 Can COBRA eligibility be provided through an online data entry system? Describe your system and the process for submitting COBRA eligibility.

1000 words.

7.5.3 How will you communicate and house enrollment eligibility for COBRA participants? Are you equipped to maintain member and dependent enrollment data for all plans?

1000 words.

7.5.4 Confirm you will also provide COBRA premium billing and collection for prescription and dental benefits.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, explain: [500 words]

7.5.5 Describe how you will track those that elect COBRA, when they are no longer eligible, when they are delinquent in premium payments, when they must be terminated and how you will communicate this information to the State, members, and/or additional vendors.

1000 words.

7.5.6 A small number of retirees (roughly 500) are considered non-pension retirees. These individuals do not collect a monthly pension check from the State or receive a monthly pension check that is not large enough to cover their monthly premium shares. Confirm that you will be able to bill and collect premiums for these individuals on behalf of the State.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, explain: [500 words]

7.5.7 In some cases, plan members on leave require direct billing. Confirm that you are willing to direct bill these members and administer late payment and termination notifications compliant with state policy.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, explain: [500 words]

7.5.8 Confirm you will also provide COBRA premium billing and collection for Partnership groups.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, explain: [500 words]

7.6 NETWORK MANAGEMENT

7.6.1 What is your firm's current book-of-business in-network utilization percentage?

Percent.

7.6.2 Please provide your network provider turnover rate.

	Current Year	Prior Year
Provider Turnover Rate	*500 words.*	*500 words.*

7.6.3 Describe separately the out-of-service area, regional, out-of-state, and out-of-country coverage for your PPO products for routine, urgent and emergency care.

500 words.

7.6.4 What criteria are used to identify situations where there is no access to in-network providers?

Single, Radio group.
1: Mileage,
2: Travel Time,
3: Other (explain): [500 words]

7.6.5 Are there any services or specialists that are not available in your physician networks in the service areas where there are plan participants? If yes, please identify them and explain what provisions are made for patients requiring these services.

1000 words.

7.6.6 If the Vendor or the State identifies a network gap or deficiency, how do you address the need for additional providers?

1000 words.

7.6.7 How often is the provider database updated?

200 words.

7.6.8 Please describe your processes for reviewing the accuracy of your provider network and demographic data in your database?

Unlimited.

7.6.9 Confirm that you will share provider network and demographic to a third party contracted with the state for a provider lookup tool.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, explain: [500 words]

7.6.10 Confirm that you will not place limitations on a third party correcting incorrect provider demographic information and will set up a process to confirm and update the information in your source data.

Single, Radio group.
1: Confirmed, Please describe [500 words] ,
2: Not Confirmed, explain: [500 words]

7.6.11 Confirm if your provider database includes the below data elements.

	Response
Provider or Facility Name	*Single, Radio group.* 1: Confirmed, 2: Not confirmed
Provider Address and telephone number	*Single, Radio group.* 1: Confirmed, 2: Not confirmed

Web address	*Single, Radio group.* 1: Confirmed, 2: Not confirmed
Medical Group	*Single, Radio group.* 1: Confirmed, 2: Not confirmed
Practicing Specialty(ies)	*Single, Radio group.* 1: Confirmed, 2: Not confirmed
Specialist Board Certified	*Single, Radio group.* 1: Confirmed, 2: Not confirmed
Providers that are not accepting new patients	*Single, Radio group.* 1: Confirmed, 2: Not confirmed
Age/gender limitations	*Single, Radio group.* 1: Confirmed, 2: Not confirmed
State Tier 1 indicator	*Single, Radio group.* 1: Confirmed, 2: Not confirmed
State Site of Service Indicator	*Single, Radio group.* 1: Confirmed, 2: Not confirmed
Provider Race/Ethnicity	*Single, Radio group.* 1: Confirmed, 2: Not confirmed
Provider Gender	*Single, Radio group.* 1: Confirmed, 2: Not confirmed
Languages Spoken	*Single, Radio group.* 1: Confirmed, 2: Not confirmed

7.6.12 Please provide a general description of how you establish your organization's networks and the corresponding financial arrangements.

500 words.

7.6.13 Do you wholly own, partially own or lease your network?

Single, Radio group.

1: Wholly own,
2: Partially own,
3: Lease,
4: Other, please specify: [500 words]

7.6.14 If you lease (or have a reciprocal agreement with) any portion of your network, describe how you will ensure continuity of care for the State's members receiving care from a provider that is part of the leased network.

1000 words.

7.6.15 Describe the claims payment process for out of network claims processed by the leased or reciprocal network. How are the out of network providers identified and communicated to the State?

1000 words.

7.6.16 Do you use a secondary (wrap) network for providers not in your primary provider network? If so, please describe the network used.

1000 words.

7.6.17 How much notice is a provider contractually required to give if they elect to terminate a contract with your network(s)?

1000 words.

7.6.18 Explain how the State will be informed of major contract disputes or potential network disruption to its members.

1000 words.

7.6.19 How do you monitor non-network utilization and what steps do you take to contract with these providers?

1000 words.

7.6.20 The State has a site of service network in which lower cost providers are preferred with a zero-dollar copay for lab services; non-preferred high-cost in-network providers have a 20% co-insurance. Please provide the criteria you would propose to identify preferred and non-preferred in-network lab and imaging providers. How often would the preferred and non-preferred tiers be reviewed and adjustments made? How would you incorporate image quality standards into the tiering criteria or prior authorization process to avoid unnecessary duplicate imaging services?

1000 words.

7.6.21 Check off those elements that are included in the provider selection process and provide the estimated percentage of network providers that satisfy the following selection criteria elements:

	In Selection Process	% of Providers
Require unrestricted state licensure	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Review malpractice coverage and history	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*

Require full disclosure of current litigation	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Require current DEA registration	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Review adherence to state and community practice standards	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Onsite review of office location	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Review hours of operation and capacity	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Board eligibility	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*
Review practice patterns and utilization results	*Single, Pull-down list.* 1: Yes, 2: No	*Percent.*

7.6.22 How do you assess physician performance? Include in your response the programs in place, the quality metrics used, and how you monitor and measure performance results.

1000 words.

7.6.23 What performance information will be shared with the State? What performance information is shared with providers? Please provide the exact algorithms used to perform physician assessments.

1000 words.

7.6.24 What percentage of physicians, non-physician providers and facilities are credentialed prior to contracting (including physicians with leased health plans or with a reciprocal arrangement)?

1000 words.

7.6.25 What classes or types of providers are not considered for credentialing? For example, are Board Certified Behavior Analysts who treat autism spectrum disorders credentialed and included in your network?

1000 words.

7.6.26 Describe your quality improvement initiatives.

1000 words.

7.6.27 How do you detect underutilization/overutilization by providers, specifically those in shared savings or risk bearing contracts? How are such situations addressed?

1000 words.

7.6.28 Confirm your willingness to provide, to the State, transparency of pricing and other financial information such as:

	Response
Billed and allowed claim costs	*Single, Pull-down list.* 1: Yes, 2: No
Terms of any risk-sharing arrangements	*Single, Pull-down list.* 1: Yes, 2: No
Incentives and pay for performance reimbursement arrangements	*Single, Pull-down list.* 1: Yes, 2: No
Future contractual rate increases by hospital	*Single, Pull-down list.* 1: Yes, 2: No
Inpatient and outpatient fee schedules as a percent of Medicare	*Single, Pull-down list.* 1: Yes, 2: No
Are you funding any of your services for subsidiaries through claims?	*Single, Pull-down list.* 1: Yes, 2: No
Is your reimbursement rates for the State plan the same as your fully insured business using the same network?	*Single, Pull-down list.* 1: Yes, 2: No
Do your provider reimbursements for the State of Connecticut plan subsidize lower reimbursements in your fully insured plan in any way?	*Single, Pull-down list.* 1: Yes, 2: No

7.6.29 Are there any CPT codes for which your fully-insured plan pays a lower reimbursement amount than the State of CT employee plan pays for the same CPT code? If yes, please disclose all CPT codes that have different reimbursement rates.

Single, Radio group.
1: Confirmed,
2: Not Confirmed (please explain): [500 words]

7.6.30 How closely do you monitor and track the performance of the DME network? Please include specifics regarding the frequency of monitoring as well as measurements.

1000 words.

7.6.31 How do you reimburse the cost of DME given to the member by the provider at the time of service or upon discharge? How is reimbursement calculated? Is there a fee schedule specific to DME when obtained as described above?

1000 words.

7.6.32 Please describe any ongoing or planned efforts to limit or lower DME costs and rationalize pricing both in and out of network.

1000 words.

7.6.33 How many provider advocates do you have working in the State of Connecticut? Please list those employees physically working in Connecticut and those working telephonically in Connecticut.

1000 words.

7.6.34 Does your organization provide satisfaction surveys to providers? If so, describe the survey and uses of results. Also share the latest results.

1000 words.

7.6.35 What are your capabilities to provide actual physician outcome quality data to members so that they can make wiser choices regarding where they seek care and, in turn, realize better and lower cost outcomes for the Plan?

1000 words.

7.6.36 Describe your Transplant network.

1000 words.

7.6.37 Do any primary care practices in your network have a mental health professional on site that can perform depression screenings and evaluate whether a patient needs behavioral health services? If so, a. Describe the behavioral health and/or depression screening programs. b. How are claims coded for these services? c. Are these services typically covered as part of preventive services, treatment of an illness, or not covered? d. Are services covered separately as part of a single visit?

Single, Radio group.
1: Yes, explain: [1000 words] ,
2: No

7.7 Behavioral Health Network Administration

7.7.1 Network Adequacy and Access

7.7.1.1 Describe the composition of your behavioral health network, including psychiatrists, psychologists, licensed clinical social workers, therapists, and substance use disorder specialists. Provide counts and provider-to-member ratios in Connecticut and nationally.

1000 words.

7.7.1.2 What percentage of your behavioral health providers are currently accepting new patients? How do you monitor this metric and update your provider directories accordingly?

500 words.

7.7.1.3 Provide average wait times for routine and urgent behavioral health appointments, broken down by region and provider type.

500 words.

7.7.1.4 Describe the criteria and process used to evaluate geographic and cultural adequacy of your behavioral health network, including rural access, bilingual provider access, and provider diversity.

500 words.

7.7.2 Network Management and Contracting

7.7.2.1 How do you credential behavioral health providers? Include required qualifications, re-credentialing cycle, and monitoring for quality and licensure.

1000 words.

7.7.2.2 Are behavioral health providers directly contracted, or are they part of leased/reciprocal networks? How do you ensure quality and continuity of care across different network types?

500 words.

7.7.2.3 What contractual strategies do you use to ensure network adequacy and manage cost growth in behavioral health services (e.g., bundled payments, case rate agreements)?

500 words.

7.7.2.4 Describe your strategy to contract with and retain high-performing behavioral health providers. Do you conduct satisfaction or performance surveys?

500 words.

7.8 Claims and Reimbursement

7.8.1 Describe your approach to adjudicating behavioral health claims. How do you ensure accuracy in coding, benefit application, and coordination with other medical services?

500 words.

7.8.2 Are reimbursement rates standardized, tiered, or negotiated individually? How do they compare to Medicare benchmarks for outpatient therapy and inpatient behavioral health care?

500 words.

7.8.3 What processes are in place to identify and resolve claim denials or errors related to behavioral health services?

500 words.

7.8.1 Integration with Medical Services

7.8.1.1 Describe how behavioral health services are integrated with medical care through claims systems, care coordination, and shared data infrastructure.

500 words.

7.8.1.2 Do you offer or facilitate co-located behavioral health models, where mental health providers are embedded in primary care settings? Please provide examples.

1000 words.

7.8.1.3 How do you support collaboration with primary care providers or ACOs for members with co-occurring conditions?

1000 words.

7.8.2 Parity Compliance (MHPAEA)

7.8.2.1 How does your organization ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA)? Describe your monitoring, internal audits, and corrective action processes.

500 words.

7.8.2.2 Provide examples of how your utilization management protocols for behavioral health match those for analogous medical services.

1000 words.

7.8.2.3 Have you been subject to any state or federal parity compliance audits in the last three years? If so, summarize the results and your response.

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

7.8.3 Member Experience and Equity

7.8.3.1 Describe your process for helping members find behavioral health providers based on location, language, clinical specialty, and cultural preference. Is live support available?

1000 words.

7.8.3.2 How do you incorporate social determinants of health and equity considerations into network design and access monitoring for behavioral health?

1000 words.

7.8.3.3 Do you provide behavioral health support via telehealth? Please list the platforms used, credentialing standards for providers, and patient satisfaction data.

500 words.

7.8.3.4 What member-facing tools (e.g., mobile apps, portals) are available to help navigate behavioral health services?

500 words.

7.8.4 PROVIDER REIMBURSEMENT

7.8.4.1 What percentage of physician contracts contain performance metrics for (1) generic or low-cost drug prescribing and (2) in-network referral for lab, imaging, and other medical services? Please provide detailed information on any metrics used in physician reimbursement, which physician types they apply to and the number of physicians in Connecticut engaged in such relationships by specialty.

1000 words.

7.8.4.2 What are your goals for the percentage of dollars at risk based on these cost-containment metrics?

1000 words.

7.8.4.3 What percentage of physician contracts contain performance metrics for improved clinical metrics (i.e. lower A1C, cholesterol, blood pressure, improved physical activity and nutrition, etc.?)

1000 words.

7.8.4.4 What are your goals for the percentage of dollars at risk based on these clinical quality metrics?

1000 words.

7.8.4.5 Describe any other value-based contracting practices you have in place both nationally and in Connecticut.

1000 words.

7.8.4.6 Describe your risk based contracting philosophy and strategy.

1000 words.

7.8.4.7 Do your contracts include retail prescription drug costs in at-risk total cost of care arrangements? If not, please indicate your willingness to expand total cost of care contracts to incorporate retail prescription drug costs for the state employee plan.

1000 words.

7.8.4.8 Can the State's members be carved out of ACO contracts with carriers to develop separate custom risk-based contracting?

1000 words.

7.8.4.9 Can you administer a State specific core set of quality metrics in addition to other metrics you may utilize?

Single, Radio group.

1: Confirmed, (please explain): [500 words] ,
2: Not Confirmed

7.8.4.10 Specialist Value based contracting Capabilities: Do you currently implement, or are you able to implement, value-based contracting arrangements with specialty providers? Please describe the structure, payment methodology (e.g., bundled payments, shared savings, downside risk), and any relevant success metrics.

1000 words.

7.8.4.11 Specialty Focus Areas: Which specialties would you recommend the state prioritize for value-based contracting under this procurement (e.g., cardiology, orthopedics, oncology, behavioral health, etc.)? Please justify your recommendations based on cost, utilization, variation, or outcome opportunity.

1000 words.

7.8.4.12 Integration with Primary Care VBC: How do your specialist-focused value-based arrangements align with or promote integration with primary care value-based strategies currently in place, or proposed under this procurement? Please describe data sharing, referral coordination, incentive, alignment, or care pathway standardization.

Unlimited.

7.8.4.13 Demonstrated Impact: What measurable outcomes (e.g., cost savings, quality improvements, patient experience) have your specialist-focused value-based arrangements achieved to date? Please include any relevant data or case studies. What impact do you anticipate similar arrangements would have for the state employee plan? Please provide a state-specific opportunity analysis using the state's claims or utilization data where available.

1000 words.

7.8.4.14 Do you have plan design recommendations (e.g., benefit differentials, tiered networks, copay waivers) that could reinforce the goals of your specialist value-based contracting strategy and encourage member engagement with high-value specialty care?

Unlimited.

7.8.4.15 Do you currently administer episode-of-care contracts? If so, please provide the following details: List of episodes (e.g., joint replacement, spinal surgery, colonoscopy) Associated facilities and/or provider groups Episode target prices and risk arrangements (e.g., prospective vs. retrospective, shared savings/loss)

1000 words.

7.8.4.16 Beyond primary care ACOs, do you have other value-based arrangements in place with large hospital systems (e.g., service-line shared risk, population health PMPMs, or gain/loss corridors)? If so, please describe and indicate whether such arrangements would be extended to the state plan.

1000 words.

7.8.4.17 Do you have or would you propose value-based arrangements with specialists that include pharmacy costs or directly seek to impact specialist prescribing patterns (e.g. aligning with the plan's formulary, generic prescribing, step therapy for certain specialty drugs)? Please describe.

1000 words.

7.8.4.18 Describe your efforts to inform providers of their performance metrics and your strategies to help providers improve quality and clinical outcomes. If risk scores are part of process, please elaborate.

1000 words.

7.8.4.19 What is the percentage of risk-based contracts your organization has in place nationally and in Connecticut specifically?

Percentage of risk-based contracts your organization has in place nationally	*Percent.*
Percentage of risk-based contracts your organization has in place in Connecticut	*Percent.*

7.8.4.20 What maximum annual increase to network provider fees will you guarantee in year 2 of this contract? For example, maximum increase may be defined as the weighted average increase in physician charges based on a uniform list of top 100 CPT codes.

1000 words.

7.8.4.21 What is the maximum annual increase to network facility fees you will guarantee in year 2 of this contract? Please define the method for defining facility fee increases.

1000 words.

7.8.4.22 How often do you monitor, and report increases in physician payments for both in- network and out-of-network providers? Will you commit to quarterly reporting to the state on changes in Connecticut provider fee schedules and hospital contracts including summaries of the changes and projected cost impact on the state plan.

1000 words.

7.8.4.23 Do you use billing and coding criteria for emergency room visits? If yes, please provide a copy of the criteria and a list of Connecticut hospitals contracted to apply the criteria. Please provide results for any hospital audits performed to ensure compliance.

1000 words.

7.8.4.24 Indicate non-network provider fees, such as UCR percentile or maximum allowable charge, used for non-network reimbursement. Please describe.

1000 words.

7.8.4.25 Describe how you assist your self-funded clients with negotiating payments to out of network providers.

1000 words.

7.8.4.26 Indicate the source of non-network provider fees (First Health, Medicare, ADP, Other).

1000 words.

7.8.4.27 Please describe any surcharges, adjustments, mark-ups or other fees that would be included in claims or applied in connection with using a network provider located outside your geographic area.

1000 words.

7.8.4.28 Do your provider contracts with network hospitals require that members be informed of the possibility of balance billing by non-network providers operating within the facility (for example, anesthesiology, radiology or emergency department services) in advance of admission to or treatment within such facility?

1000 words.

7.8.4.29 Indicate what percentage of facility reimbursement is through the following types of payments for the network being proposed:

	Inpatient Hospital (%)	**Outpatient Hospital (%)**	**Other Outpatient Facilities (%)**

DRG	*Percent.*	*Percent.*	*Percent.*
APC or other OP per case	*Percent.*	*Percent.*	*Percent.*
Discount off Charges	*Percent.*	*Percent.*	*Percent.*
Bundled Payment	*Percent.*	*Percent.*	*Percent.*
Per diem rate (by bed type)	*Percent.*	*Percent.*	*Percent.*
Per diem rate (global)	*Percent.*	*Percent.*	*Percent.*
Other (specify in additional rows)	*Percent.*	*Percent.*	*Percent.*
Total	**100%**	**100%**	**100%**

7.8.4.30 Describe how network hospitals are reimbursed. If reimbursement varies by geographic location, identify reimbursement arrangements by area for those relevant to the State's membership. Please be specific for each Connecticut hospital.

Predominant Area: *State of Connecticut*	**Full Service Hospital Acute Care Inpatient Facility**	**Full Service Hospital Acute Care Outpatient Facility**	**Ambulatory Surgical Facility**	**Behavioral Health Facilities**	**Other**
Number of Hospitals/ Facilities	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Hospital Payment Method Per diem, per admission, other describe:	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Ratio of network hospital charges to Medicare payment	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Minimum network hospital discount guarantee (as a ratio of Medicare payments)	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
What overall maximum increase to network hospital room and board rates will you guarantee in the second year of this contract?	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*

7.8.4.31 Please provide the scheduled rate increases and effective dates of such rate increases for each hospital as required by existing provider contracts. Please break-out by in-patient and out-patient by hospital.

1000 words.

7.8.4.32 How are network outpatient facilities such as surgicenters, imaging centers and laboratories reimbursed (on a discounted fee arrangement, percent of Medicare APCs, prepaid capitated arrangement)? If a scheduled fee arrangement is the basis for reimbursement, describe how the scheduled fees are derived.

1000 words.

7.8.4.33 The State is interested in understanding the movement in your discounts over time. Illustrate the change in your provider discounts, as a percentage increase or decrease, for each of the past five (5) years. Please provide them separately for hospital inpatient, hospital outpatient, and professional services.

1000 words.

7.8.4.34 Describe any other contractual relationships you maintain with any other providers such as pharmacies, physical therapists, orthotics suppliers, prosthetic suppliers, vision care and home health care providers.

1000 words.

7.8.4.35 Explain any financial incentives (bonuses) or disincentives (withholds) in network provider contracts or for network hospitals that are tied to utilization goals, specialty referrals, member survey results, readmission rates, quality of care outcomes or other performance results.

1000 words.

7.8.4.36 Do you offer provider incentives for disincentives for prescribing practices (e.g. % generic, % formulary, etc.) if so can such arrangement apply to the state despite our pharmacy carveout (assume the state and current vendor will share any required claims data or other information).

Unlimited.

7.8.4.37 Please provide the contract expiration date and anticipated renegotiation date for each hospital in the State of Connecticut. If you anticipate renegotiating provider contracts in the next 12, 24 or 36 months please describe the planned changes and anticipated impact on your book-of-business premium rates.

1000 words.

7.8.4.38 Please provide a sample contract that you use for network hospitals.

Single, Radio group.

1: Attached,
2: Not Attached

7.8.4.39 Please provide a copy of your current contracts with all hospitals in the State of Connecticut and confirm you will provide copies of each new contract throughout the term of the agreement.(Note the state is

reimbursing providers based upon the terms of such agreements and requires transparency to understand and confirm they are paying appropriate amounts)

Single, Radio group.
1: Attached,
2: Not Attached

7.8.4.40 Please disclose any revenue billed through claims retained by the bidder, its subcontractor or subsidiary including spread pricing, or services billed as claims or any other mechanism by which revenue is retained by the bidder through a claim.

1000 words.

7.8.4.41 Please disclose if your provider contracts reimburse providers less, (always or in specific circumstances) for any fully insured book of business administered by the bidder, and affiliated or subsidiary entity. Please describe.

500 words.

7.8.4.42 Do you offer “gold carding” (eliminated or reduced prior authorization and pre-certification requirements) to any providers in your Connecticut network, if so please list the gold carded providers, services and criteria to earn the designation.

1000 words.

7.9 TIERED NETWORKS AND HIGH-PERFORMANCE NETWORKS

7.9.1 Describe your current tiered-network and high quality/high performance network capabilities.

1000 words.

7.9.2 What impact do you expect these will have on trend? Please provide results for each year of the contract.

1000 words.

7.9.3 Describe your programs to evaluate physicians and facilities for your high quality/performance network, specifically addressing the following: Criteria (e.g., quality, cost, efficiency) How is quality information conveyed to plan enrollees? What are your sources of quality and performance information on physicians and facilities?

1000 words.

7.9.4 Do you currently rank providers based on quality and/or cost? If “yes” how do you determine the specific quality ranking of each provider and facility? How often is each provider's quality ranking revisited?

1000 words.

7.9.5 Please identify tiered or high-performance network providers by notations in provider directory submitted with your proposal or on a separate listing.

1000 words.

7.9.6 Confirm that information regarding Connecticut providers and their designated tier category is made available to the members so they can make informed decisions about the cost and quality of the provider they choose.

Single, Radio group.
1: Confirmed,
2: Not confirmed

7.9.7 Is your system capable of administering plan design differentials when a tiered network is in place?

Single, Radio group.
1: Yes,
2: No

7.9.8 Do you have a minimum benefit differential requirement between Tier 1 and Tier 2? If so, what is the minimum differential?

1000 words.

7.9.9 How do you engage and drive consumers to use high quality, high performance medical providers in your high-performance network?

1000 words.

7.9.10 What type of reporting will you provide to the State regarding your high quality, high performance medical providers?

1000 words.

7.9.11 The state is considering using a third party vendor to set its provider tiering. Confirm you can administer tiering set by a third party, assume the third party will provide any required regular data feeds.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

7.9.12 If the State uses a third-party vendor to seists provider tiering. Confirm you will share your book of business deidentified Connecticut. claims data with the vendor to improve the accuracy of the State's tiering.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

7.10 STRATEGIES TO MANAGE HIGH-COST CLAIMANTS

7.10.1 The state has experienced a significant increase in both the number and cost of high-cost claimants. What specific strategies do you recommend to: Reduce the number of members reaching catastrophic spend levels, Lower the total cost of care for individual high-cost claimants?

1000 words.

7.10.2 Please describe any contracting strategies you have in place to manage high-cost claimants, particularly in arrangements where your organization assumes risk (e.g., stop-loss, case rate caps, shared risk corridors, targeted vendor partnerships).

1000 words.

7.10.3 Do you offer any clinical programs, vendor solutions, or care management strategies specifically designed for high-cost members?

Single, Radio group.
1: Yes, (please describe): [500 words] ,
2: No

7.10.4 The state is willing to consider shared risk arrangements with tertiary hospitals that commit to jointly managing the cost of high-cost claimants. Would your organization be willing to facilitate such arrangements? If so, please describe a proposed structure (e.g., stop-loss thresholds, risk corridors, gain/loss sharing).

Single, Radio group.
1: Yes, (please describe): [500 words] ,
2: No

7.10.5 Do your facility network discounts remain constant regardless of the cost of care, or do they adjust (e.g., ratchet down or cap out) once high-cost thresholds are exceeded?

500 words.

7.10.6 Do you currently pursue or are you willing to pursue single case agreements with facilities to reduce total costs for high-cost episodes of care? Please describe your approach, negotiating authority, and turnaround time.

500 words.

7.10.7 Would you be willing to share financial risk on high-cost claimants for the state plan? If so, please describe a proposed model (e.g., specific deductible threshold, coinsurance, maximum exposure) and any conditions for participation.

Single, Radio group.
1: Yes, (please describe): [500 words] ,
2: No

7.10.8 Please describe how you negotiate/partner with facilities and providers when it becomes clear that there will be a very high claimant.

1000 words.

7.10.9 Do you offer a pooled protection product for gene therapy drugs? Please describe and provide pricing.

Single, Radio group.
1: Yes, (please describe): [500 words] ,
2: No

7.11 MEDICAL PHARMACY

7.11.1 General

7.11.1.1 Do you currently have contracted rates with network providers for drugs administered though the medical benefit? Do they include rebates?

1000 words.

7.11.1.2 Are you able to work with the PBM to secure aggressive rebates on claims processed under the medical benefit? If so, please explain your process.

1000 words.

7.11.1.3 Describe your reporting and monitoring of prescription drugs administered through the medical benefit. What information is tracked? What patterns and trends do you monitor?

1000 words.

7.11.1.4 How will you manage price increases for medications (such as oncology drugs or other infusions) that are administered through the medical benefit plan?

1000 words.

7.11.1.5 Explain your philosophy to formulary development, including how evidence-based guidelines (e.g., National Comprehensive Cancer Network (NCCN) guidelines or similar are considered for special populations?

500 words.

7.11.1.6 Please attach your current medical pharmacy formulary.

Single, Radio group.
1: Attached,
2: Not attached, explain: [500 words]

7.11.1.7 Do you collect rebates based on client utilization of formulary drugs?

Single, Radio group.
1: Yes,
2: No

7.11.1.8 Are you willing to pass through all collected rebates to the State?

Single, Radio group.
1: Yes,
2: No, explain: [500 words]

7.11.1.9 How do you work with hospitals and providers to ensure optimal utilization of the formulary?

500 words.

7.11.1.10 Describe your process for managing medication shortages, including communication strategies with clients and providers How do you ensure continuity of care for patients affected by these shortages?

500 words.

7.11.1.11 Do you have experience working with formulary management consultants? If not, are you willing to collaborate with the State's consultants to make custom adjustments to your formulary? Do any customizations affect rebates?

500 words.

7.11.1.12 Do you have your own Pharmacy and Therapeutics Committee? If you can, please describe their role in the formulary review process and clinical utilization management overview.

500 words.

7.11.1.13 Describe how much transparency and supporting evidence you will provide the State of Connecticut in advance of any changes proposed to the Drug Formulary and Utilization Management programs.

500 words.

7.11.1.14 Can you work with an existing utilization management vendor to coordinate?:

	Response
Formulary development and custom formulary changes?	*Compound, Pull-down list.* 1: Yes, 2: No, explain: [500 words]
Clinical rules such as prior authorization, step therapy, and quantity limits?	*Compound, Pull-down list.* 1: Yes, 2: No, explain: [500 words]
Rebate management?	*Compound, Pull-down list.* 1: Yes, 2: No, explain: [500 words]

7.11.1.15 What is your experience in coordinating care with prescribers, PCPs, and others?

500 words.

7.11.1.16 Please list the full network of entities and infusion sites that are part of or affiliated with your organization.

Unlimited.

7.11.1.17 Explain your process for steering care to the lowest clinically appropriate site of care.

500 words.

7.11.1.18 What are your average wait times for appointments at the proposed locations?

100 words.

7.11.1.19 Describe the services offered at your proposed locations.

500 words.

7.11.1.20 How do you manage patient quality and satisfaction? Share any data you may have.

500 words.

7.11.1.21 What quality measures do you track?

500 words.

7.11.1.22 Are your providers willing to work with us to leverage manufacturer assistance? Would there be additional fees for the administrative work involved?

500 words.

7.11.1.23 What are your estimated discount ranges for preferred partners (both provider office and hospital-based)?

500 words.

7.11.1.24 What other questions should the State ask when considering the creation of a preferred infusion network?

500 words.

7.11.1.25 Does your organization manage manufacturer copay assistance programs for infused and specialty medications? If so, outline the services provided.

500 words.

7.11.1.26 Do you partner with an outside vendor for this program, or is it managed in-house?

100 words.

7.11.1.27 Please attach a list of all drugs currently included in your manufacturer copay assistance program.

Single, Radio group.

1: Attached,
2: Not attached, explain: [500 words]

7.11.1.28 Explain the registration and enrollment process for patients to participate in the manufacturer copay assistance program.

500 words.

7.11.1.29 How do you structure your fees?

500 words.

7.11.1.30 Are any guarantees included in your program?

500 words.

7.11.1.31 What does your reporting include?

500 words.

7.11.1.32 Please attach a sample report.

Single, Radio group.
1: Attached,
2: Not attached, explain: [500 words]

7.11.1.33 How do you communicate program details and member out-of-pocket costs?

500 words.

7.11.1.34 Describe your process and timing for billing the manufacturer for rebates. List and describe all detail included on manufacturer billing. Does the manufacturer require NDCs or any other billing code to be sent with rebate invoices?

1000 words.

7.11.1.35 Provide and describe your Connecticut book-of-business breakdown of medical-pharmacy services by site-of-service (IP, OP, Physician Office, Infusion Center, Home Health, other).

1000 words.

7.11.1.36 Describe how drugs are received and billed by distribution channel (buy and bill, specialty pharmacy, home health, etc.) for the site-of-service providers (IP, OP, Physician Office, Infusion Center, Home Health, other). Include in your response the percentages by distribution channel.

1000 words.

7.11.1.37 Describe internal protocols for reviewing buy and bill invoices, particularly for outliers.

1000 words.

7.11.1.38 Describe biosimilar strategies including education for providers and/or prescriber influence.

1000 words.

7.11.1.39 Describe utilization management for prior authorizations, site of care steerage, dose optimization, and reconciliation when adjudicating claims.

1000 words.

7.11.1.40 Who is providing utilization management for oncology and non-oncology drugs?

1000 words.

7.11.1.41 Provide your book-of-business PA denial, appeal, and overturn rates for oncology and non-oncology.

1000 words.

7.11.1.42 Describe your rebate reporting to OSC and provide a sample.

1000 words.

7.11.1.43 For cross channel drugs, describe your ability to block NDCs, if moved to the pharmacy channel.

1000 words.

7.11.1.44 Primary Care Integration & PCI Coordination 7.13.3.1. How do you coordinate care with primary care practices, especially those participating in the PCI program? Include processes for:

a. Receiving and sharing care management notes
b. Coordinating post-discharge outreach for high-risk members
c. Scheduling follow-up care within defined timeframes
d. Aligning clinical goals and quality metrics

1000 words.

7.11.1.45 Describe your ability and willingness to customize workflows for PCI-aligned providers, including:

a. Real-time notification and engagement after an inpatient or ED discharge
b. Joint case management or warm handoffs
c. Data sharing, including lab and EMR integration
d. Reporting on shared patients' outcomes and compliance

1000 words.

7.11.1.46 Social Determinants, Equity & Data Integration 7.13.4.1. Describe your approach to incorporating health equity, including the collection and use of race, ethnicity, and language data.

500 words.

7.11.1.47 How does your program address social determinants of health (SDOH)? Include examples of how SDOH data informs care planning or referrals to community resources.

1000 words.

7.11.1.48 Detail your capability to integrate and use external data sources such as lab data, EMR feeds (e.g., CONNIE), and pharmacy claims. What is your strategy for bridging data gaps?

500 words.

7.11.1.49 Clinical Guidelines & Quality Assurance 7.13.5.1 What clinical guidelines or evidence-based protocols are used in your programs? How often are they updated and by whom?

500 words.

7.11.1.50 Are your programs accredited (e.g., NCQA, URAC)? List accreditations and status.

100 words.

7.11.1.51 Describe your approach to quality assurance, staff credentialing, and training. Include your staffing model for Connecticut.

1000 words.

7.11.2 Behavioral Health & High-Cost Case Management

7.11.2.1 Describe your approach to behavioral health integration and your services for substance use and opioid management.

500 words.

7.11.2.2 How do you identify and intervene early with potential high-cost or catastrophic claimants?

500 words.

7.11.2.3 Describe your willingness to share financial risk or participate in high-cost case strategies that involve collaboration with tertiary providers or shared risk corridors.

500 words.

7.11.3 Staffing and Capacity

7.11.3.1 Describe your proposed staffing model to support the clinical care management functions for the State of Connecticut. Include your expected number of full-time equivalents (FTEs) by role (e.g., RNs, LPNs, health coaches, behavioral health specialists, clinical supervisors, support staff), and describe how staffing levels may flex seasonally or in response to call volume or programmatic needs.

500 words.

7.11.3.2 Indicate whether staff assigned to the State of Connecticut will be:

- Dedicated: assigned only to this contract; or
- Designated: shared with other clients but specifically trained to support this population.

Please describe the rationale for your proposed staffing configuration and how it ensures continuity and quality.

500 words.

7.11.3.3 Describe the qualifications, training, and clinical credentials of the staff who will be responsible for:

a. Member engagement and care coordination
b. High-cost/catastrophic case management
c. Behavioral health management
d. Provider coordination (especially with PCI-aligned primary care groups)

500 words.

7.11.3.4 What proportion of your care management team currently holds RN, LPN, or other clinical credentials? Please provide counts or percentages and indicate any required continuing education or training for those individuals.

500 words.

7.11.3.5 Explain your approach to training and onboarding clinical and non-clinical staff who will support this contract. How do you ensure staff understand state-specific requirements such as HEP compliance, PCI integration, health equity reporting, and data security standards?

500 words.

7.11.3.6 If selected, will you commit to maintaining minimum staffing levels by function (clinical, customer service, IT/data, program oversight)? Please describe your strategy for managing vacancies and how you will ensure uninterrupted service delivery during transitions.

500 words.

7.11.3.7 For the first three years of the contract please provide the estimated number (by function/and Full Time Equivalent [FTE]) of the following personnel to be assigned to the State of Connecticut:

Position	**Year 1**	**Year 2**	**Year 3**
Care Managers	*Integer.*	*Integer.*	*Integer.*
RN's	*Integer.*	*Integer.*	*Integer.*
LPN's	*Integer.*	*Integer.*	*Integer.*
Call Center Employees	*Integer.*	*Integer.*	*Integer.*
IT Staff Members	*Integer.*	*Integer.*	*Integer.*

7.12 FRAUD, WASTE AND ABUSE

7.12.1 Describe your existing programs for detecting fraud, waste and abuse in connection with self-insured medical benefit plans and whether you participate in any joint anti-fraud efforts with other industry, regulatory or law enforcement organizations.

1000 words.

7.12.2 How do you monitor fraud, waste and abuse relative to out-of-network claims?

1000 words.

7.12.3 How do you measure success for your organization's fraud, waste and abuse prevention programs?

1000 words.

7.12.4 Confirm that you will provide monthly written reports and quarterly meetings with OSC staff on fraud waste and abuse findings by individual provider.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

7.12.5 Confirm that you will send copies of all notices sent to providers regarding required policies and procedures to the Healthcare Policy & Benefit Division of the Office of the State Comptroller and, if requested, the Connecticut Attorney General in connection with plan administration, referrals and/or investigations conducted pursuant to the Connecticut False Claims Act (Connecticut General Statutes Section 4-274 et seq.)

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

7.12.6 Confirm that you will provide notice and consult with the Office of the State Comptroller and with the Connecticut Attorney General, if necessary, prior to suspending payments to a provider or attempting recovery of any funds in a matter in which fraud, waste or abuse are suspected.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

7.12.7 In cases requiring participation by the Connecticut Attorney General, confirm that you will adhere to the Connecticut Attorney General's reasonable requests to allow the maximum opportunity to investigate the matter pursuant to the Connecticut False Claims Act.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

7.13 PARTNERSHIP PLAN

7.13.1 Can you set up each Partnership Group's eligibility and billing structure by group and subgroup based on each Partnership's group's individual needs?

Single, Pull-down list.
1: Yes,
2: No,
3: N/A

7.13.2 Will each Partnership group administrator have access to their own eligibility portal?

Single, Pull-down list.
1: Yes,
2: No,
3: N/A

7.13.3 Will the Partnership group administrator have the ability to make eligibility changes directly through your portal?

Single, Pull-down list.
1: Yes,
2: No,
3: N/A

7.13.4 Will there be a separate account management and service team for the Partnership? If yes, describe the number of employees dedicated to the Partnership plan and the roles of each.

200 words.

7.13.5 Please confirm that you have the ability to bill each Partnership group separately for payment of premium based on negotiated premium equivalent rates and then wire those funds to the State.

Single, Pull-down list.
1: Yes,
2: No,
3: N/A

7.13.6 Partnership groups will need educational support for members and administrators regarding plan design, network, point solutions, eligibility, and billing upon implementation of the plan or at open enrollment. Will the service team be staffed for this purpose?

Single, Pull-down list.
1: Yes,
2: No,
3: N/A

7.14 NON-BARGAINED INNOVATION PLAN

As discussed, OSC is very interested in proposals for a customized high-performance network plan for the non-bargained innovation offering. The non-bargained plan currently in place is “Quality First Select Access”. It is not necessary to duplicate this plan design.

Your proposed plan design should leverage and drive membership to high performing providers and facilities while providing cost savings to the State and its members. If you are not providing a proposal for this plan, you may respond n/a.

7.14.1 Please describe the plan and how it accomplishes the State's goals?

1000 words.

7.14.2 What types of medical providers/facilities are in this plan?

1000 words.

7.14.3 How are providers reimbursed in the proposed plan?

500 words.

7.14.4 Is this a national network offering or Connecticut-only? Please describe the geographic access to providers.

500 words.

7.14.5 What impact do you expect this plan will have on initial costs and trend as compared to the other collectively bargained plans offered by the State? Please provide results for each year of the contract and demonstrate evidence for your assumed total cost and trend.

1000 words.

7.14.6 Does this plan operate on a unique network or is built on an existing network used by other plan designs? If this is a unique network, are the network reimbursements on average the same, lower or higher than your broad network offerings for the following services:

- In-patient hospital
- Out-patient hospital
- Surgicenters
- Labs
- Physician Services

Unlimited.

7.14.7 Describe your programs to evaluate physicians and facilities for this plan, specifically addressing the following: Criteria (e.g., quality, cost, efficiency) How is quality information conveyed to plan enrollees? What are your sources of quality and performance information on physicians and facilities?

1000 words.

7.15 DATA AND REPORTING

7.15.1 Describe capabilities are that are available to State staff through your employer portal (i.e., view eligibility changes and validate eligibility data, view claims, pull standard reports, create customized ad hoc reports, etc.)?

1000 words.

7.15.2 Indicate the reports you can provide on both a quarterly and an annual basis:

Multi, Checkboxes.
1: Financial Claim Update,
2: Utilization Review,
3: Network Utilization,
4: Clinical Review,
5: Preventive services,
6: Case Management,
7: Large Claimants,
8: Hospital Inpatient Review,
9: Maternity Program,
10: Other Programs

7.15.3 Detail the full package of available reports and indicate which reports are available to the State on-line.

1000 words.

7.15.4 Provide a sample of weekly detailed claims and enrollment data downloads including file layouts and documentation.

Single, Pull-down list.
1: Sample attached,
2: Sample not attached.

7.15.5 Confirm that there is no additional cost for these reports and electronic data downloads as required by the State.

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

7.15.6 Describe the requirements on the user/client site to access your site (i.e. levels of passwords required for users to log onto the site).

1000 words.

7.15.7 Confirm that your organization will provide to OSC monthly detailed claims data in a mutually agreed upon format, including run out claims, in event of termination, as applicable.

Single, Pull-down list.
1: Confirmed,
2: Not Confirmed

7.15.8 Indicate the earliest possible availability of detailed claims data for analysis. Can your systems provide information to the State and its vendors about member utilization within 24 hours of occurrence?

1000 words.

7.15.9 What tools do you offer clients to spot and identify trends in claim information?

500 words.

7.15.10 Do you charge for ad hoc or customized reports? If so, please explain.

Single, Radio group.
1: Yes,
2: No,
3: Other, please specify: [500 words]

7.15.11 With regard to your computer systems, please describe your record retention and destruction policy, including how long records are retained.

Unlimited.

7.15.12 What types of security do you have with regard to your website and the transfer of data?

Unlimited.

7.16 AUDITS

7.16.1 Once each year, or more frequently as reasonably determined by the State, or within two (2) years following termination of this Agreement, Client's third party Auditor(s) (“Auditor”), as reasonably approved by Vendor (which approval shall not be unreasonably withheld), may inspect and verify claim data, eligibility, billing records, pricing discounts and terms, claims adjudication systems, healthcare benefits, clinical programs, subcontracted administrative services directly related to Client's Member utilization and services, performance guarantees, and operational processes relating to the services provided to Client pursuant to this Agreement to ensure Vendor's compliance with the terms and conditions of this Agreement, as Client deems appropriate.

Single, Radio group.
1: Agree,
2: Disagree

7.16.2 Such audits may be based on either a 100% review of claims or a statistically representative sample thereof, or combination of methodologies. Auditor's preliminary findings will be shared with Vendor. Any findings from a statistically representative sample of claims will be extrapolated to the total claims population for purposes of measuring overall financial dollar and incidence processing achievements; Vendor will produce financial impact reports for confirmed systemic errors. In the instance where Auditor has reviewed 100% of claims and identified suspect claims, Vendor may elect to review a mutually-agreed upon representative sample of the suspect claims and any findings from such sample of claims will be extrapolated to the total claims population of suspect claims for purposes of measuring overall financial dollar and incidence processing achievements .

Single, Radio group.
1: Agree,
2: Disagree

7.16.3 The audit may include an onsite review of the sample claims by the Auditor at Vendor's office. The Auditor will provide Vendor with the sample claims thirty (30) calendar days in advance of the onsite review. The onsite review will last up to five (5) business days.

Single, Radio group.
1: Agree,
2: Disagree

7.16.4 Confirm the scope of such audits may include up to three (3) benefit plan years as determined by the State.

Single, Radio group.
1: Agree,
2: Disagree

7.16.5 Indicate whether you agree with the following statements regarding audits.

	Response
You will allow auditing of your operations as they relate to the administration and servicing of this account.	*Single, Radio group.* 1: Agree, 2: Disagree
Your organization will not charge for services rendered in conjunction with the audit.	*Single, Radio group.* 1: Agree, 2: Disagree
If problems are discovered, the cost of follow-up audits will be paid by your organization.	*Single, Radio group.* 1: Agree, 2: Disagree
Vendor agrees to fund up to $35,000 for a pre-implementation audit.	*Single, Radio group.* 1: Agree, 2: Disagree

7.16.6 The State via its auditor has the right to perform additional audits during the year of similar scope if performed as a follow-up to ensure significant/material errors found in a previous audit have been corrected and are not recurring or if additional information becomes available to warrant further investigation.

Single, Radio group.
1: Confirmed,
2: Not confirmed

7.16.7 The State via its auditor has the right to audit post termination of service contract.

Single, Radio group.
1: Confirmed,
2: Not confirmed

7.16.8 Your organization will provide a response to all findings received within 30 days of audit, or at a later date if mutually determined to be more reasonable based on the number and type of findings.

Single, Radio group.
1: Confirmed,
2: Not confirmed

7.16.9 Confirm you will allow an auditor selected by the State to audit all provisions governed by the contract.

Single, Radio group.
1: Confirmed,
2: Not confirmed

7.16.10 Confirm you agree not to charge the State for EOBs/claims issued as corrections due to audits.

Single, Radio group.
1: Confirmed,
2: Not confirmed

7.16.11 Any and all costs and expenses of each party associated with State's audit shall be borne by the party incurring the cost. the parties agree that the scope of audits by Client or Auditor will not be duplicative of the SSAE-18 audit, but may include inspection and/or verification of certain information provided in the SSAE-18 audits to the extent necessary to give a more thorough understanding of and support for such information. Audit materials or documentation provided by Vendor will be confined to client-specific information. Confirm your agreement with this provision.

Single, Radio group.
1: Confirmed,
2: Not confirmed

7.16.12 If the audit discovers any validated overpayment of fees or claim payments by Vendor or other errors that result in economic losses to the client for failure to meet all vendor guarantees or performance standards, then Vendor shall pay the amount owed to the State following completion of the audit, within 30 days of written confirmation from the client as to the agreed upon settlement terms and amounts. Confirm your agreement with this provision.

Single, Radio group.
1: Confirmed,
2: Not confirmed

7.16.13 Vendor agrees to grant the right of the State or its representative(s) to audit claims at any time during and up to two years following termination of the business relationship with prior written notification. The State will have access to 100% of all valid claim records to complete the audit at no cost to the plan sponsor. Bidder agrees to provide all necessary claims details, data definitions and reasonable support to complete an independent claim audit for each completed year under the contract in effect. The State will not be held responsible for time or miscellaneous costs incurred by the bidder in association with an audit including, but not limited to, the costs associated with providing audit reports, systems access, or onsite space.

Single, Radio group.
1: Confirmed,
2: Not confirmed

7.17 FINANCE AND BANKING

7.17.1 What data/electronic information is needed to coordinate billing between you and the State for services provided?

500 words.

7.17.2 The State makes payment in arrears, provides claims reimbursements twice per month, and administrative fees once per month at the end of the month. Confirm you will adhere to this schedule.

Single, Radio group.
1: Confirmed,
2: Not confirmed

7.17.3 What payment options are available to the State?

Single, Radio group.
1: ACH,
2: Wire transfer,
3: Other: [500 words]

7.17.4 Confirm you will not charge interest on negative cash flow for any delay of wire transfer.

Single, Pull-down list.
1: Confirmed,
2: Not confirmed

7.17.5 Confirm that the State will not be charged for reissued checks or drafts.

Single, Pull-down list.
1: Confirmed,
2: Not confirmed

7.17.6 Confirm that you will accept fiduciary responsibility for claims processing at no additional charge.

Single, Radio group.
1: Confirmed,
2: Not confirmed

8 QUESTIONNAIRE - Member Advocacy

8.1 General

8.1.1 Describe any unique strategies or services (or customizations to current products and services) that you would recommend specific to our organization that are not explicitly requested in the scope of this RFP.

500 words.

8.1.2 Please describe what differentiates you and your proposed model from other marketplace competitors.

500 words.

8.1.3 What is your NPS score?- use the last 6 months of data only? Please describe the criteria for eliciting NPS responses from members and the total number of responses and response rate for the prior 6 months.

Integer.

8.1.4 Please describe your philosophy and approach to advocacy services and how it improves the member experience.

500 words.

8.1.5 Please describe the team that will service the client in the following questions in the chart below:

	Details
a) Proposed location(s) for care coordination and consumer navigation team	*100 words.*
b) Proposed customer service hours	*20 words.*
c) How are calls outside of business hours handled?	*100 words.*
d) What is your turnaround time for responding to calls received after hours?	*20 words.*
e) Number of team members that will service the client's account in total	*Integer.*
f) Number of team members per team if co-located together	*Integer.*
g) Job title of each team member per team	*100 words.*
h) Total number of clients served	*Integer.*
i) Number of clients serviced by each team	*Integer.*

8.1.6 Are all the individuals who will service the client's members co-located? If so, please described how this differs from other organizations. What percent of the team will work at home and/or offshore?

500 words.

8.1.7 What is the constitution of the team that will service our account in total? What are the roles of the member services and clinical teams and how many of each?

500 words.

8.1.8 Is this a "dedicated team" or "designated team"? For the purpose of this RFP, "Dedicated" is defined as the Vendor's staff members are solely assigned to perform Services in furtherance of this Contract, which means the Vendor does not assign them to work for any other client or customer. "Designated" is defined as

the Vendor's staff members are assigned to perform Services in furtherance of this Contract but may also be assigned to work for other clients or customers.

Single, Radio group.
1: Dedicated,
2: Designated

8.1.9 If this a designated team, how many other clients will they serve?

Single, Radio group.
1: Yes: [Integer] ,
2: No

8.1.10 What are your required credentials/experience for team members?

500 words.

8.1.11 Once you hire a team member, please detail the training they undergo, including: whether they receive coaching/feedback based on role play and how and how you determine whether a new hire is ready to start handling member calls.

500 words.

8.1.12 Please describe the qualities that your most effective team members possess. On an ongoing basis, what evaluation criteria are used to determine the effectiveness of your staff? How often are evaluations conducted and by whom?

500 words.

8.1.13 Please explain what happens once a member calls into the call center with an inquiry for the first time.

	Response
Who answers the call and are they routed to other team members?	*100 words.*
How many team members might the member be handed off to?	*100 words.*
How does a call typically end? Is the member provided a written summary?	*500 words.*
Also describe the answer to these questions for repeat callers.	*500 words.*

8.1.14 Describe the process, tools, resources, approach to getting the member to the right care and right place.

500 words.

8.1.15 Please describe what happens if team members are not able to resolve the member's inquiry.

500 words.

8.1.16 Please describe your interaction/process for working with family members of an employee if they are ill.
500 words.

8.1.17 Please describe your process for obtaining HIPAA releases to contact other vendors, providers or facilities on the members' behalf.
500 words.

8.1.18 Please complete the following table for each care coordination and consumer navigation feature.

PROGRAM NAVIGATION AND EDUCATION	Response
a) Answer benefit coverage questions	*Single, Radio group.* 1: Yes, 2: No
b) Educate members about new or changing health plan benefits	*Single, Radio group.* 1: Yes, 2: No
c) Assist in finding a PCP, Specialist or in-network facility or lab	*Single, Radio group.* 1: Yes, 2: No
d) Locate physicians, hospitals, Centers of Excellence (medical and behavioral)	*Single, Radio group.* 1: Yes, 2: No
e) Seek local and community support groups	*Single, Radio group.* 1: Yes, 2: No
f) Educate members about programs such as HEP, Point Solutions, DPP	*Single, Radio group.* 1: Yes, 2: No
g) Arrange for home-care equipment following discharge from the hospital	*Single, Radio group.* 1: Yes, 2: No
h) Help to identify and coordinate a range of services such as preventive screenings and other covered services	*Single, Radio group.* 1: Yes, 2: No
i) Provide information for obtaining or renewing prescriptions	*Single, Radio group.* 1: Yes, 2: No

j) Obtain referrals for required services such as specialist, EAP or Behavioral Health referrals	*Single, Radio group.* 1: Yes, 2: No
k) Assist members in locating in-network providers and outreach to members if referred to an out-of-network provider	*Single, Radio group.* 1: Yes, 2: No
l) Help members understand the processing for obtaining coverage for medical equipment, devices, and supplies	*Single, Radio group.* 1: Yes, 2: No
m) Coordinate homecare needs and services to facilitate hospital discharge	*Single, Radio group.* 1: Yes, 2: No
n) Coordinate benefits with spouse's plan or between health and ancillary health vendors	*Single, Radio group.* 1: Yes, 2: No
o) Outreach to and coordinate with primary care physician groups for care coordination and member HEP requirements	*Single, Radio group.* 1: Yes, 2: No
p) Educate and coordinate use of telemedicine	*Single, Radio group.* 1: Yes, 2: No
q) Educate and coordinate use of specialty networks	*Single, Radio group.* 1: Yes, 2: No
CLAIMS ASSISTANCE	
r) Explain how to read an EOB	*Single, Radio group.* 1: Yes, 2: No
s) Research a member's outstanding out-of-pocket responsibilities and resolve errors with providers and/or member's health plan	*Single, Radio group.* 1: Yes, 2: No
t) Review questionable bills to catch duplicate or erroneous charges	*Single, Radio group.* 1: Yes, 2: No
u) Resolve questions over whether services are condition specific or related to preventive care	*Single, Radio group.*

	1: Yes, 2: No
v) Resolve incorrect plan procedure interpretations such as hospital procedures denied for lack of pre-certification	*Single, Radio group.* 1: Yes, 2: No
w) Resolve errors in the application of deductible and/or co-payments	*Single, Radio group.* 1: Yes, 2: No
x) Resolve questions about denial of benefits deemed to be non-covered, not medically necessary or ineligible	*Single, Radio group.* 1: Yes, 2: No
y) Provide payers with additional information required to correctly pay a claim or apply a benefit	*Single, Radio group.* 1: Yes, 2: No
z) Retroactive audit of bills and statements	*Single, Radio group.* 1: Yes, 2: No
aa) Provide appeals and grievance support	*Single, Radio group.* 1: Yes, 2: No
FEE NEGOTIATION	
bb) Negotiate fees with out of network healthcare providers to possibly lower the member's out-of-pocket costs PRIOR to service	*Single, Radio group.* 1: Yes, 2: No
cc) Negotiate fees with out of network healthcare providers AFTER service has been rendered	*Single, Radio group.* 1: Yes, 2: No
CLINICAL GUIDANCE	
dd) Explain a diagnosis	*Single, Radio group.* 1: Yes, 2: No
ee) Explain the recommended treatment	*Single, Radio group.* 1: Yes, 2: No
ff) Provide quality and outcomes data to help decision making	*Single, Radio group.*

	1: Yes, 2: No
gg) Arrange for second opinions	*Single, Radio group.* 1: Yes, 2: No
hh) Assess whether member has gaps in care (Rx or preventive) and triage to appropriate clinical program	*Single, Radio group.* 1: Yes, 2: No
ii) Discuss potential alternative options with provider on member's behalf	*Single, Radio group.* 1: Yes, 2: No
jj) Provide clinical information requested by members	*Single, Radio group.* 1: Yes, 2: No
kk) Clinical telephone support by a nurse for non-urgent health issues (Nurseline)	*Single, Radio group.* 1: Yes, 2: No
ll) Help members identify alternative treatments for specific conditions	*Single, Radio group.* 1: Yes, 2: No
mm) Help members understand results from a biometric screening or other lab tests	*Single, Radio group.* 1: Yes, 2: No
nn) Help members understand drug interactions if there are any	*Single, Radio group.* 1: Yes, 2: No
oo) Troubleshoot pharmacy issues involving tiered pharmacy benefits, mail order, formularies, or point-of-sale eligibility problems at the pharmacy	*Single, Radio group.* 1: Yes, 2: No
SPECIAL SERVICE SUPPORT	
pp) Assess family unit needs as a result of the patient's condition and provide resources and referrals	*Single, Radio group.* 1: Yes, 2: No
qq) Assess barriers to treatment and make recommendations on how to remove barriers	*Single, Radio group.* 1: Yes, 2: No

rr) Locate homemaker, adult day care and rehabilitation services not covered by the member's health plan	*Single, Radio group.* 1: Yes, 2: No
ss) Locate inpatient private duty nursing or home health aids	*Single, Radio group.* 1: Yes, 2: No
tt) Help members complete qualification applications for individual coverage options, including Medicaid	*Single, Radio group.* 1: Yes, 2: No
uu) Provide members with access to experts for consultations and second opinions	*Single, Radio group.* 1: Yes, 2: No
vv) Help members find an appropriate mental health provider; educate members on what mental health services are	*Single, Radio group.* 1: Yes, 2: No
ww) Arrange hospice and other services for terminally ill patients	*Single, Radio group.* 1: Yes, 2: No

8.1.19 What percentage of the member population and/or member households contacts your call center annually?

500 words.

8.1.20 Is your primary model an inbound, outbound or some mixed approach to connecting with members/ families?

500 words.

8.1.21 Do you provide a solution that will support the member's caregiver/family and/or those who are not part of the client benefits (i.e., family member mother, father, sister, brother)?

500 words.

8.1.22 What is your average talk time with members?

Integer.

8.1.23 What percentages of inbound and outbound contact do you have with members? Please describe how you balance the goals of resolving the member's concern with helping the member to become a better health care consumer.

500 words.

8.1.24 What is the range of member inquiries that customer service representatives are trained to respond to? If customer service representatives are trained to respond to clinical questions, please describe how.

500 words.

8.1.25 Describe how you would assist members with prescription questions or challenges.

500 words.

8.1.26 What is your approach to specialty pharmacy support?

500 words.

8.1.27 How do you support the member's financial issues and assist them to make better financial healthcare decisions?

500 words.

8.1.28 How will your organization integrate with the client's vendor partners?

500 words.

8.1.29 Do you collect and report race and ethnicity data?

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

8.1.30 How does your program address health equity?

500 words.

8.1.31 How does your program address social determinants of health that may contribute to the manifestation or severity of chronic diseases?

500 words.

8.1.32 Please detail how you work with third party medical claims administrators.

What is the typical level of day to day engagement, etc.

1000 words.

8.1.33 Describe any issues or challenges you've experienced in working with third party medical claims administrators

1000 words.

8.1.34 Does any health plan or pharmaceutical company have equity ownership in your organization? If so, please explain why and how these organizations obtained equity in your company.

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

8.1.35 How do you show evidence of the impact of your program with regard to identification, engagement, behavior change, clinical outcomes and financial outcomes? Provide sample reporting.

500 words.

8.1.36 How do you define engagement? How do you define and measure utilization? Number of calls, emails, cases, opened, number of closed cases, etc. What is your 2019 or 2020 book-of-business member identification, utilization, and engagement rate?

500 words.

8.1.37 Please describe your best practices for driving engagement.

500 words.

8.2 Technology and Security

8.2.1 Please describe the system (purchased, internally customized, proprietary) used by your health care navigation team during calls with the client's members.

500 words.

8.2.2 Do claims, customer service and clinical staff have access to the same systems or have access to each other's systems?

500 words.

8.2.3 Please describe how the system setup helps address member issues holistically. Are there alerts or notifications that direct the concierge to discuss any programs or benefits that may be applicable to the member?

500 words.

8.2.4 Describe your member website and/or app.

500 words.

8.2.5 Please describe your ability to integrate with third-party vendors. Be specific about referral/transfer processes, back-end view capabilities, access to tools on desktops, etc.

500 words.

8.2.6 Have you integrated with and supported other non-traditional plan design models and vendors such as Reference Based Pricing, narrow networks, direct contracting, and if so, please describe.

500 words.

8.2.7 Please confirm your ability and willingness to refer out to other benefit resources and point solutions and partner with us to design what benefits should be shared with members and when.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

8.2.8 What is your experience with digital integrations with any third-party vendors (i.e., ability for single sign-on)?

500 words.

8.2.9 Do you have preferred partners or pre-integrated partners that we could leverage under a single contract? If so, how do reporting and performance metrics factor into those relationships and contract obligations?

500 words.

8.2.10 Please list all of your partners and level of integration with each

	Point Solution Provided?	Vendor Partner and Integration	Fee Arrangement	Included in the Current Proposal
a. Weight Management	*Single, Pull-down list.* 1: Yes, 2: No	*10 words.* N/A OK.	*10 words.* N/A OK.	*Single, Pull-down list.* 1: Yes, 2: No
b. Physical Therapy	*Single, Pull-down list.* 1: Yes, 2: No	*10 words.* N/A OK.	*10 words.* N/A OK.	*Single, Pull-down list.* 1: Yes, 2: No
c. Physical Activity	*Single, Pull-down list.* 1: Yes, 2: No	*10 words.* N/A OK.	*10 words.* N/A OK.	*Single, Pull-down list.* 1: Yes, 2: No
d. Diabetes Prevention Program	*Single, Pull-down list.* 1: Yes, 2: No	*10 words.* N/A OK.	*10 words.* N/A OK.	*Single, Pull-down list.* 1: Yes, 2: No
e. Diabetes	*Single, Pull-down list.* 1: Yes, 2: No	*10 words.* N/A OK.	*10 words.* N/A OK.	*Single, Pull-down list.* 1: Yes, 2: No
f. Hypertension	*Single, Pull-down list.* 1: Yes, 2: No	*10 words.* N/A OK.	*10 words.* N/A OK.	*Single, Pull-down list.* 1: Yes, 2: No

g. Behavioral Health / Substance Abuse	*Single, Pull-down list.* 1: Yes, 2: No	*10 words.* N/A OK.	*10 words.* N/A OK.	*Single, Pull-down list.* 1: Yes, 2: No
h. Infertility / Maternity	*Single, Pull-down list.* 1: Yes, 2: No	*10 words.* N/A OK.	*10 words.* N/A OK.	*Single, Pull-down list.* 1: Yes, 2: No
i. Other	*Single, Pull-down list.* 1: Yes, 2: No	*10 words.* N/A OK.	*10 words.* N/A OK.	*Single, Pull-down list.* 1: Yes, 2: No

8.2.11 .2.11 What data do you track regarding referrals to third-party vendors? Please provide a sample

500 words.

8.2.12 What increases in engagement have you documented from your BOB that can be shared.

500 words.

8.2.13 Please detail how you ensure that member data is kept secure. Include all certifications, external audits etc. that you have regarding data security. Please state how many people in the organization have visibility to the client's member's data (Personal Health Information and Confidential Information).

500 words.

8.2.14 Please describe how you will ensure no disruption in service to members in case of a disaster.

500 words.

8.2.15 Please detail your process for systems user acceptance testing, ongoing system performance monitoring and systems issue resolution. If the website or telephone systems are down, what alternative methods are in place to minimize disruption for the client's membership?

500 words.

8.3 Website/app and Lookup Tool

8.3.1 Does your benefits website/app have the flexibility to incorporate the State benefits branding “Care Compass”?

Single, Pull-down list.

1: Yes,

2: No

8.3.2 Does your website/app allow for clients to directly access and update benefits information and messaging? Please define specific areas of the site that are adjustable. Can clients directly adjust content in these areas or is it require to be updated by your staff? If the latter, how quickly are updates processed?

Single, Radio group.
1: Yes, explain: [500 words] ,
2: No

8.3.3 Can your website/app host benefit forms, rate information and other plan documents?

Single, Pull-down list.
1: Yes,
2: No

8.3.4 Please provide a demo link to your website/app here.

10 words.

8.3.5 Can you display other vendor partners and programs and allow single-sign on access to their portals when necessary?

Single, Pull-down list.
1: Yes,
2: No

8.3.6 Can your portal be customized to allow members to view their HEP compliance status and upload documentation of compliance when necessary.

Single, Pull-down list.
1: Yes,
2: No

8.3.7 Can you incorporate or provide single sign-on access to a provider lookup tool managed by a third party vendor (the State uses Embold today)

Single, Pull-down list.
1: Yes,
2: No

8.4 HEALTH ENHANCEMENT PROGRAM ADMINISTRATION and SUPPORT

Please review the HEP program description. The program requires an annual communication campaign to inform members of their requirements and non-compliance as the end of the measurement period approaches and again before penalties apply. The State requires that members have the ability to check their status through an online portal and through direct phone calls. Phone calls have significant spikes at the close of measurement periods and prior to the application of the final penalty as members respond to communications notifying them of their compliance status.

8.4.1 Describe your approach to monitoring member compliance with annual HEP requirements using medical, pharmacy, and dental claims.

1000 words.

8.4.2 What is the expected claims lag you account for when determining compliance? How is late claim adjudication handled?

500 words.

8.4.3 Explain your process for using claims data to identify HEP members with the following chronic conditions: diabetes (types I and II), asthma, COPD, coronary artery disease, hypertension, and hyperlipidemia.

1000 words.

8.4.4 How do you update and refine chronic condition identification over time (e.g., annually, based on new diagnostic codes)?

500 words.

8.5 CLINICAL CARE MANAGEMENT

8.5.1 Program Overview & Population Health Strategy

8.5.1.1 Please describe your clinical care management model, including how it supports total population management and aligns with value-based reimbursement models such as those used in Connecticut's Primary Care Initiative (PCI).

1000 words.

8.5.1.2 Provide a list of chronic conditions covered under your care management programs. Indicate which are clinically integrated (e.g., comorbidities addressed in a unified plan), how long each program has been operational, and whether any are outsourced.

500 words.

8.5.1.3 Explain your strategy for identifying members for clinical intervention (e.g., predictive analytics, ADT feeds), and how you stratify members by risk level. Include how often risk scores are updated.

500 words.

8.5.1.4 Describe how you measure program effectiveness and ROI, including examples of past performance. Include how you measure engagement and the definition of “active participation.”

500 words.

8.5.2 Member Engagement & Accessibility

8.5.2.1 How do you ensure accessibility and engagement for members across language, literacy, disability, and technology access barriers?

500 words.

8.5.2.2 Describe your multichannel member engagement strategy (e.g., calls, email, app, SMS) and the cadence of outreach for each modality.

500 words.

8.5.2.3 Do you provide condition-specific coaching or education (e.g., diabetes, asthma, weight loss)? How are priorities set for members with multiple conditions?

500 words.

8.5.2.4 Describe your in-house vs. partnered approach to coaching and education. Include telephonic, in-person, mobile, and digital options.

500 words.

8.5.2.5 Provide examples of successful strategies used to increase engagement or behavior change among hard-to-reach members.

1000 words.

8.6 Digital Engagement Platform

8.6.1 Describe the functionality of your proposed web- and app-based portal. How will members use the system to: - View HEP requirements by age and chronic condition - Track individual and family member compliance status - Receive reminders and alerts - Access chronic disease education and wellness content

Please provide dummy ID login information and/or screen shots for review purposes.

1000 words.

8.6.2 How do you ensure accessibility of the portal for users with disabilities (ADA compliance)?

500 words.

8.6.3 What data security and privacy protocols are in place to protect members' health and claims information?

500 words.

8.7 Reporting to OSC

8.7.1 What formats and frequencies do you support for compliance reporting to the Office of the State Comptroller?

500 words.

8.7.2 How do you reconcile data across claim feeds to ensure accurate compliance status prior to reporting?

500 words.

8.7.3 Describe your ability to support the Health Care Cost Containment Committee and provide reports or member data for compliance enforcement and disqualification votes.

500 words.

8.7.4 How do you track and report delivery and engagement rates?

500 words.

8.8 Communication

8.8.1 Describe your workflow for contacting providers to confirm that a member has received a preventive service when no claim has been received.

500 words.

8.8.2 What methods of provider outreach do you use (e.g., phone, fax, electronic)? What is your average turnaround time for confirming services?

500 words.

8.8.3 How can members notify you of services they've received that have not yet resulted in a claim? What steps follow in the member notification?

500 words.

8.8.4 Describe your communications program, including:
- Initial annual communication of HEP requirements
- Monthly or periodic reminders to members about compliance
- Tailored communications based on member or household compliance status

500 words.

8.8.5 What is your approach for issuing escalating notices to non-compliant members (including warning letters)?

1000 words.

8.8.6 How do you coordinate communications with OSC, partnership group, and union representatives regarding impending disqualification?

500 words.

8.8.7 What communication channels do you support (e.g., print, email, SMS, portal messages)?

500 words.

8.9 Compliance and Member Satisfaction

8.9.1 How would you propose increasing member engagement in HEP services throughout the year?

500 words.

8.9.2 How would you measure participant satisfaction within your program?

500 words.

8.9.3 How do you measure the success in administering the HEP program, which KPIs would you track? Explain.

500 words.

8.9.4 Describe your approach to quality assurance (accurate administration and data) and the process of reporting to OSC.

500 words.

8.10 Call Center

8.10.1 How many dedicated call center staff would you dedicate to the HEP program. What are your call center hours of operation in terms of hours per day and days per week? Identify the process for members/physicians to contact clinicians after hours.

500 words.

8.10.2 Can you administer both inbound and outbound calls. For example, the HEP administrator currently assists members by confirming compliance by directly outreaching to providers to confirm required services have been received. They also assist with making appointments. Would you provide these services and or propose other methods for assisting members in complying with the program?

500 words.

8.10.3 Is the member's clinical information and HEP status available during each call with that member or the member's physician? Explain.

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

8.10.4 Explain how member clinical information is captured and stored.

500 words.

8.10.5 Due to the nature of the HEP program, which applies monetary penalties for participants who don't comply with the program requirements, call volume related to HEP compliance can vary drastically throughout the year with typical volume between 200 and 400 calls a week, jumping to over 5,000 calls a week as deadline for imposition of non-compliance penalty approaches. How would you propose handling such variation in call volume? What opportunities do you have to train and leverage additional staff to avoid long wait times? Please note average call time during peak periods is about 7 to 8 minutes a call currently.

500 words.

8.11 Data Exchange

8.11.1 What data (e.g., claims, eligibility) do you require from the health plan to support program components? What is the frequency required for each data set? What is the typical time frame form receipt of such data to it being loaded and available in your system?

500 words.

8.11.2 How are you able to receive these data sets? Describe your system for collecting and maintaining member and physician data.

500 words.

8.11.3 Confirm that you will generate a reconciliation eligibility file monthly or on demand and that this file will be reconciled to the billing.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

8.11.4 Describe your data warehouse.

500 words.

8.11.5 Provide a listing of reports that are available to the health plan and the provider.

500 words.

8.11.6 How flexible is your system in meeting ad hoc reporting needs? Is there an extra charge for these reports?

500 words.

8.11.7 What is your process to grant access, and how does your company respond to access-related technical issues?

500 words.

8.11.8 In what format does your system accept lab data? (EHR direct from physician practices via an electronic feed?)

100 words.

8.11.9 Can you load union codes and utilize for reporting purposes?

Single, Pull-down list.
1: Yes,
2: No

8.11.10 Has an independent consulting firm reviewed your database system? If so, provide details.

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

8.11.11 Outline your company's future growth plans general and specifically in the advocacy arena. Please include specifics related to your product and infrastructure roadmap.

500 words.

8.11.12 Please describe your firm's expected use of emerging solutions and technologies within the healthcare industry (e.g., Artificial Intelligence, Machine Learning, Natural Language Processing, Social Determinants of Health).

500 words.

8.11.13 What are your current and projected investments to keep up with the vendor marketplace on enhancing your data and technology? Include a separate attachment which outlines your roadmap enhancements for the next 2-3 years.

500 words.

9 QUESTIONNAIRE Primary Care Initiative (PCI) Administrations

9.1 Administration

9.1.1 Please describe your experience with administering custom, risk-based provider contracts on behalf of your clients.

500 words.

9.1.2 Please describe your ability and willingness to administer the program design of the Primary Care Initiative provided in the description in the introduction to this RFP.

500 words.

9.1.3 Do you have the ability to ingest EMR data both supplemental and from the State Health Insurance Exchange (CONNIE).

500 words.

9.1.4 Are you willing to integrate with the State's other partners (point solutions, advocacy, weight loss etc.) so that provider groups may engage with, refer to and receive information from these partners? Please describe in detail how you would accomplish this.

1000 words.

9.1.5 Do you have the ability to ingest pharmacy data from the State's PBM?

Single, Radio group.
1: Yes,
2: No

9.1.6 Will administration and reporting be fully automated by July 1, 2026. This means that all components of the program, quality metrics calculations, financial performance, risk adjustment pharmacy data including pricing data and attribution will all be fully automated to allow for real-time reporting to the State and provider groups through your population health reporting tools.

Single, Radio group.
1: Yes,
2: No

9.1.7 The administration of this program requires enrollment and attribution management, confirm that you will update enrollment and eligibility files and report at least monthly.

Single, Radio group.
1: Yes,
2: No

9.1.8 Please describe how you engage and assist providers in value-based arrangements to improve their performance on quality and total cost of care metrics.

500 words.

9.1.9 Explain how your strategies differ by provider type - hospital affiliated, independent employed practices and IPAs.

500 words.

9.1.10 Please describe the specific intervention strategies that you work with provider groups to implement:

Identification of high-performing specialist	*100 words.*
Site of care opportunities	*100 words.*
Generic and high value prescription options	*100 words.*
Gaps in care	*100 words.*
Managing chronic disease	*100 words.*
High risk and latent risk patients	*100 words.*
Other	*100 words.*

9.2 Financial Performance Analysis

9.2.1 Confirm that you will share your reconciliation and Risk adjustment methodology with the State.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

9.2.2 Reconciliation of financial performance occurs annually, with shared savings or loss payments finalized by July following the close of the measurement year. Providers may opt for lump-sum settlements or installment payments over six months for any owed amounts. The State is interested in reconciliation models that are as close to real-time as possible and pay out shared savings and loss at or near the end of the reconciliation period without significant delays). Confirm that you will administer this arrangement.

Single, Radio group.
1: Yes,
2: No

9.2.3 How will you provide support on provider engagements (webinars, working groups etc.)?

1000 words.

9.2.4 Confirm that you will update provider panels with changes submitted by providers at least monthly. Please describe any other efforts you take to ensure accurate provider panel attribution in the program.

Single, Radio group.
1: Confirmed, please describe: [500 words] ,
2: Not confirmed

9.2.5 What tools do you have to identify high performing specialists and how is such information shared with primary care groups participating in a value-based arrangement to improve specialist referral patterns?

1000 words.

9.3 Staffing

The selected bidder must have a dedicated program staff including: clinical, data, project management, contracting with a broader, designated team providing technical, healthcare economics and data integration. The program is currently staffed with 7 dedicated team members consisting of: 1 Provider Collaboration Director, 1 Provider Network Manager, 2 Provider relationship account managers, 3 Care Consultants

9.3.1 Please detail your vision of how this this team will be staffed.

1000 words.

9.3.2 How would hours be allocated for key designated teams?

500 words.

9.3.3 Will you be fully staffed by July 1, 2026?

Single, Radio group.
1: Yes,
2: No, explain: [500 words]

9.3.4 Will you commit to replacement hiring within defined timelines (depending on role).

Single, Radio group.
1: Yes,
2: No, explain: [500 words]

9.3.5 Please confirm that OSC will have final approval of finalist candidates for key positions.

Single, Radio group.
1: Yes,
2: No, explain: [500 words]

9.4 Reporting

9.4.1 Participating provider groups expect accurate and timely financial, quality and population health reporting.

Please confirm your ability and willingness to provide:

Monthly claims feed updates	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [200 words]
Pre-certification data sharing (weekly or daily)	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [200 words]

Identification and reporting of high-risk members	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [200 words]
Annual release of technical specifications 30 days prior to reconciliation.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [200 words]
Ability to take in EMR data both supplemental data and feeds from Connie and incorporate into quality reporting	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [200 words]
Ability to share raw claims data (medical, pharmacy) monthly	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [200 words]
Real-time financial and quality performance reporting: · Relative to benchmarks, State plan, book of business, and government sector. · Reporting on all Quality Council metrics including equity and SDOH measures.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [200 words]
Comprehensive population health tool with: · Employer access · Full incorporation of State pharmacy data including pricing · Ability to integrate the plan's formulary · Providers of Distinction · Stratification capabilities by race, ethnicity, and language	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [200 words]

10 QUESTIONNAIRE - Municipal Employee Health Insurance Plan (MEHIP) Administration

10.1 Describe how your firm/company will meet each of the requirements listed in Section 2.3 Scope of Services.

200 words.

10.2 Provide examples of performance guarantees with organizations of similar size to the State of Connecticut.

200 words.

10.3 Describe internal controls and audit trail as well as reporting for user access and use of the system(s).

200 words.

10.4 Describe your plan to protect data, related reporting, analytics, and other intellectual property.
200 words.

10.5 Provide a detailed project plan and implementation timeline for managing the Program.
200 words.

10.6 Provide a breakdown of fees associated with the proposed services.
200 words.

10.7 Detail available service enhancements and the associated costs.
200 words.

11 QUESTIONNAIRE Utilization Management and Clinical Care Management

As noted above, this service will be awarded as part of Claims Administration or Member Advocacy

11.1 Utilization Management

11.1.1 Which services and procedures do you currently require utilization management or prior authorization for? Please include both inpatient and outpatient services, diagnostics, therapies, and specialty medications (administered under the medical benefit).
500 words.

11.1.2 Describe your flexibility to customize UM requirements in accordance with the State Plan's benefit design and Plan Document. Specifically, how do you add, remove, or modify authorization requirements at the client's request?
500 words.

11.1.3 How do you determine when and where UM or pre-certification is clinically appropriate? Please include information on any medical necessity criteria, clinical guideline sources (e.g., MCG, InterQual), and processes for periodic review and updating.
1000 words.

11.1.4 Describe how you notify providers of services that require pre-certification. Include the mechanisms used (e.g., provider portals, email, fax), the frequency of provider updates, and how you ensure awareness of current UM rules.

1000 words.

11.1.5 Is your UM criteria made readily available to providers? If so, how is it shared (e.g., provider portal, downloadable PDF, embedded tooltips)? Is the full clinical rationale included?

Single, Radio group.
1: Yes, describe,
2: No

11.1.6 Describe the ways providers may submit authorization requests. Please include:
a. Secure web-based portals or EHR integrations
b. Phone/fax capabilities
c. Mobile-enabled tools
d. Real-time decision tools or electronic authorization feedback

500 words.

11.1.7 When providers submit incomplete or insufficient documentation, how does your team follow up? Describe outreach protocols and timelines for obtaining the necessary information before issuing a determination.

100 words.

11.1.8 Complete the following table regarding utilization management metrics for the most recent 12-month period (calendar or fiscal):

Please include totals for your Book of Business, and if possible, public sector clients of comparable size.

Service Type	**Total Requests**	**Denials (#)**	**Denial Rate (%)**	**Appeals (#)**	**Appeal Rate (%)**	**Overturn Rate (%)**
Inpatient Medical	*Integer.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Percent.*
Outpatient Procedures	*Integer.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Percent.*
Imaging Services (e.g., MRI, CT)	*Integer.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Percent.*
DME/Prosthetics	*Integer.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Percent.*
Behavioral Health	*Integer.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Percent.*
Medical Benefit Drugs	*Integer.*	*Integer.*	*Percent.*	*Integer.*	*Percent.*	*Percent.*
Other (specify)	*100 words.*	*100 words.*	*100 words.*	*100 words.*	*100 words.*	*100 words.*

11.1.9 Do you support the sharing of pre-certification data with at-risk provider groups (e.g., participating PCI providers)? If yes, explain your approach, data format, and frequency.

Single, Radio group.
1: Yes, explain: [500 words] ,
2: No

11.1.10 Do you utilize prior authorization or pre-certification processes to steer members to high-value providers, sites of service, or centers of excellence? If so, describe how this process is implemented and monitored.

Single, Radio group.
1: Yes, describe: [500 words] ,
2: No

11.1.11 How do you leverage pre-certification data to identify members for clinical care management programs? Please describe how often such referrals occur, and how they are communicated to care managers.

500 words.

11.1.12 Provide evidence of how utilization management supports or improves your care navigation and care management services. Include specific examples of:

- Redirecting care to lower-cost, higher-value sites or providers
- Early identification of high-risk members
- Integration with HEP compliance outreach
- Outcomes from coordinated follow-up

1000 words.

11.1.13 Describe any success metrics or return-on-investment (ROI) measures you track related to your UM program. Include results from client case studies or relevant data you are authorized to share.

1000 words.

11.2 Primary Care Integration & PCI Coordination

11.2.1 How do you coordinate care with primary care practices, especially those participating in the PCI program? Include processes for:

a. Receiving and sharing care management notes
b. Coordinating post-discharge outreach for high-risk members
c. Scheduling follow-up care within defined timeframes
d. Aligning clinical goals and quality metrics

1000 words.

11.2.2 Describe your ability and willingness to customize workflows for PCI-aligned providers, including:

a. Real-time notification and engagement after an inpatient or ED discharge
b. Joint case management or warm handoffs
c. Data sharing, including lab and EMR integration
d. Reporting on shared patients' outcomes and compliance

1000 words.

11.3 Social Determinants, Equity & Data Integration

11.3.1 Describe your approach to incorporating health equity, including the collection and use of race, ethnicity, and language data.

1000 words.

11.3.2 How does your program address social determinants of health (SDOH)? Include examples of how SDOH data informs care planning or referrals to community resources.

1000 words.

11.3.3 . Detail your capability to integrate and use external data sources such as lab data, EMR feeds (e.g., CONNIE), and pharmacy claims. What is your strategy for bridging data gaps?

500 words.

11.4 Clinical Guidelines & Quality Assurance

11.4.1 What clinical guidelines or evidence-based protocols are used in your programs? How often are they updated and by whom?

500 words.

11.4.2 Are your programs accredited (e.g., NCQA, URAC)? List accreditations and status.

500 words.

11.4.3 Describe your approach to quality assurance, staff credentialing, and training. Include your staffing model for Connecticut.

1000 words.

11.4.4 Behavioral Health & High-Cost Case Management

Unlimited.

11.4.5 Describe your approach to behavioral health integration and your services for substance use and opioid management.

1000 words.

11.4.6 How do you identify and intervene early with potential high-cost or catastrophic claimants?

1000 words.

11.4.7 .3. Describe your willingness to share financial risk or participate in high-cost case strategies that involve collaboration with tertiary providers or shared risk corridors.

500 words.

11.5 Staffing and Capacity

11.5.1 Describe your proposed staffing model to support the clinical care management functions for the State of Connecticut. Include your expected number of full-time equivalents (FTEs) by role (e.g., RNs, LPNs, health coaches, behavioral health specialists, clinical supervisors, support staff), and describe how staffing levels may flex seasonally or in response to call volume or programmatic needs.

500 words.

11.5.2 Indicate whether staff assigned to the State of Connecticut will be:

- Dedicated: assigned only to this contract; or
- Designated: shared with other clients but specifically trained to support this population.

Please describe the rationale for your proposed staffing configuration and how it ensures continuity and quality.

500 words.

11.5.3 Describe the qualifications, training, and clinical credentials of the staff who will be responsible for:

a. Member engagement and care coordination
b. High-cost/catastrophic case management
c. Behavioral health management
d. Provider coordination (especially with PCI-aligned primary care groups)

500 words.

11.5.4 What proportion of your care management team currently holds RN, LPN, or other clinical credentials? Please provide counts or percentages and indicate any required continuing education or training for those individuals.

500 words.

11.5.5 Explain your approach to training and onboarding clinical and non-clinical staff who will support this contract. How do you ensure staff understand State-specific requirements such as HEP compliance, PCI integration, health equity reporting, and data security standards?

500 words.

11.5.6 If selected, will you commit to maintaining minimum staffing levels by function (clinical, customer service, IT/data, program oversight)? Please describe your strategy for managing vacancies and how you will ensure uninterrupted service delivery during transitions.

500 words.

11.5.7 For the first three years of the contract please provide the estimated number (by function/and Full Time Equivalent [FTE]) of the following personnel to be assigned to the State of Connecticut:

Position	Year 1	Year 2	Year 3

Care Managers	*Integer.*	*Integer.*	*Integer.*
RN's	*Integer.*	*Integer.*	*Integer.*
LPN's	*Integer.*	*Integer.*	*Integer.*
Call Center Employees	*Integer.*	*Integer.*	*Integer.*
IT Staff Members	*Integer.*	*Integer.*	*Integer.*

12 Financial Section and Network Access

Responses are due in electronic Excel format provided, where noted.

12.1 Medical Claims Administration - Administrative Services Only Fees

12.1.1 Medical Administrative Services Only Fees are requested for the three-year period July 1, 2026, through June 30, 2029 with the option for plan years beginning July 1, 2029 and July 1, 2030. Fees should be on a per subscriber (contract) per month basis. Please provide responses only as applicable for your quote. Fees must be submitted in the format provided.

Basic Medical Administrative Services as outlined in Section 2.3	**Initial 3-Year Contract - 7/1/2026**	**Initial 3-Year Contract - 7/1/2027**	**Initial 3-Year Contract - 7/1/2028**	**Option Year 4 - 7/1/2029**	**Option Year 5 - 7/1/2030**
All Inclusive Fee (PCPM)	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Breakdown of costs of services included in all inclusive fees (for informational purposes and should not be additive to fee above)					
Medical Administration / Claims Processing	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Network Access/Leasing Fees	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Behavioral Health Services	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
TeleHealth	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
ID Cards	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Benefit Summaries/Benefit Booklets	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Data Reporting	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Banking	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Claim Fiduciary	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
COBRA Administration	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Member Communications	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Subrogation	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*

Fees related to data sharing and data feed exchanges with State's vendor partners	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Start Up/Implementation Costs	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Other Base Administrative Costs	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Other Base Admin Description:	*Compound, Pull-down list.* 1: Includes: [200 words], 2: Not applicable				

12.1.2 Confirm fees exclude commissions.

Single, Radio group.
1: Yes,
2: No

12.1.3 Fees quoted are valid until contract award & guaranteed for each 12-month period.

Single, Radio group.
1: Yes,
2: No, explain [500 words]

12.1.4 Confirm individual fee components are self-supporting for standalone services.

Single, Radio group.
1: Yes,
2: No, explain [500 words]

12.1.5 Confirm fees quoted cover services for claims incurred on or after July 1, 2026.

Single, Radio group.
1: Yes,
2: No

12.1.6 Confirm fees are inclusive of all implementation costs.

Single, Radio group.
1: Yes,
2: No, explain [500 words]

12.1.7 Confirm all fees are on a mature basis and include at least 18 months of runout administration.

Single, Radio group.
1: Yes,
2: No, explain [500 words]

12.1.8 Confirm fees assume the full value of your provider discounts will be passed through to the State on each and every claim and that no portion of the provider discounts are retained to offset the administrative fees.

Single, Radio group.
1: Yes,
2: No, explain [500 words]

12.2 Member Advocacy and Health Enhancement Program Administration Fees

12.2.1 Member Advocacy and Health Enhancement Program (HEP) Administration Fees are requested for the three-year period July 1, 2026 through June 30, 2029 with the option for plan years beginning July 1, 2029 and July 1, 2030. Fees should be on a per subscriber (contract) per month basis. Please provide responses only as applicable for your quote. Fees must be submitted in the format provided.

Member Advocacy and HEP Administration as outlined in 2.3	**Initial 3-Year Contract - 7/1/2026**	**Initial 3-Year Contract - 7/1/2027**	**Initial 3-Year Contract - 7/1/2028**	**Option Year 4 - 7/1/2029**	**Option Year 5 - 7/1/2030**
Member Advocacy All Inclusive Fee (PCPM)	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Breakdown of costs of services included in all inclusive fees (for informational purposes and should not be additive to fee above)					
Member Services and Navigation	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Open Enrollment Support	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
HEP Administration	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Toll Free Member Services Line	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
24-Hour Nurseline	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Start Up/Implementation Costs	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Other Advocacy Costs	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Other Advocacy Description:	*Compound, Pull-down list.* 1: Includes: [200 words], 2: Not applicable				

12.2.2 Confirm fees exclude commissions.

Single, Radio group.
1: Yes,
2: No

12.2.3 Fees quoted are valid until contract award & guaranteed for each 12-month period.

Single, Radio group.
1: Yes,
2: No, explain [500 words]

12.2.4 Confirm individual fee components are self-supporting for standalone services.

Single, Radio group.
1: Yes,
2: No, explain [500 words]

12.2.5 Confirm fees quoted cover services for claims incurred on or after July 1, 2026.

Single, Radio group.
1: Yes,
2: No

12.2.6 Confirm fees are inclusive of all implementation costs.

Single, Radio group.
1: Yes,
2: No, explain [500 words]

12.3 Utilization Management Services

Utilization management services will be awarded with either the Medical TPA services or Member Advocacy services.

12.3.1 Utilization Management Fees are requested for the three-year period July 1, 2026 through June 30, 2029 with the option for plan years beginning July 1, 2029 and July 1, 2030. Fees should be on a per subscriber (contract) per month basis. Please provide responses only as applicable for your quote. Fees must be submitted in the format provided.

Utilization Management Service (Awarded with Medical TPA or Advocacy)	**Initial 3-Year Contract - 7/1/2026**	**Initial 3-Year Contract - 7/1/2027**	**Initial 3-Year Contract - 7/1/2028**	**Option Year 4 - 7/1/2029**	**Option Year 5 - 7/1/2030**
Utilization Management	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Clinical Care Management	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*

12.3.2 Confirm fees exclude commissions.

Single, Radio group.
1: Yes,
2: No

12.3.3 Fees quoted are valid until contract award & guaranteed for each 12-month period.

Single, Radio group.
1: Yes,
2: No, explain [500 words]

12.3.4 Confirm individual fee components are self-supporting for standalone services.

Single, Radio group.
1: Yes,
2: No, explain [500 words]

12.3.5 Confirm fees quoted cover services for claims incurred on or after July 1, 2026.

Single, Radio group.
1: Yes,
2: No

12.3.6 Confirm fees are inclusive of all implementation costs.

Single, Radio group.
1: Yes,
2: No, explain [500 words]

12.4 Primary Care Initiative (PCI) Administration Fees

12.4.1 PCI Administration Fees are requested for the three-year period July 1, 2026 through June 30, 2029 with the option for plan years beginning July 1, 2029 and July 1, 2030. Fees should be on a per subscriber (contract) per month basis. Please provide responses only as applicable for your quote. Fees must be submitted in the format provided.

PCI Administration as outlined in 2.3	**Initial 3-Year Contract - 7/1/2026**	**Initial 3-Year Contract - 7/1/2027**	**Initial 3-Year Contract - 7/1/2028**	**Option Year 4 - 7/1/2029**	**Option Year 5 - 7/1/2030**
PCI Program Administration All Inclusive Fee (PCPM)	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Breakdown of costs of services included in all-inclusive fees (for informational purposes and should not be additive to fee above)					
Program Administration and Operations	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Reporting and Analytics	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Staffing & Technical Resources	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Start Up/Implementation Costs	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Other PCI Costs	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*

12.4.2 Confirm individual fee components are self-supporting for standalone services.

Single, Radio group.
1: Yes,
2: No, explain [500 words]

12.4.3 Confirm fees quoted cover services for claims incurred on or after July 1, 2026.

Single, Radio group.
1: Yes,
2: No

12.4.4 Confirm fees are inclusive of all implementation costs.

Single, Radio group.
1: Yes,
2: No, explain [500 words]

12.5 Self-Funded Mature Expected Claims

12.5.1 Confirm completion of the Self-Funded Projected Claims chart in the attached Excel spreadsheet. Provide the mature expected claims per employee per month for the State and Partnership plans separately. **[See "5 Self-Funded Claim Pick" tab in State of CT - July 1, 2026 RFP Attachment File.xlsx]**

Single, Radio group.
1: Attached,
2: Not provided

12.6 Claim Costs - Provider Reimbursement and Discounts

This section refers to spreadsheets that must be completed based on the current network provider contracts and experience. Worksheets should be completed separately for select locations or for a composite of all network areas (if specific location is not requested). **Responses are due in the electronic Excel format provided.**

12.6.1 Claims Repricing Analysis

12.6.1.1 Please reprice the claims provided in the detailed claims experience files referenced in the Appendix. The repricing should be based on eligible charges (column "ELIGIBLE_CHARGES" on the repricing claims files) and your current (as of July 1, 2025) network provider contractual fee arrangements. **The claims repricing amounts must be based on actual data and should not include any assumptions regarding projected discounts or assumed increases in billed charges.**

- Provide the sum of all repriced claims by the State and Partnership plans, by category (Inpatient, Outpatient, Physician/Professional) and by in-network and out-of-network based on the eligible charges in the column "ELIGIBLE_CHARGES". If you are proposing alternative networks for any of the current plans, copy the tab and provide another complete exhibit.
- Bidders must break out all fees/charges that apply to the claim. This includes, but not limited to, network access fees, "host" plan fees, percent of savings fees, estimated attribution payments, estimated additional reimbursements for Provider Risk Sharing Arrangements, and any additional fees paid to vendors or providers that apply to the claim payment. The amounts should be stated as requested in the "Claims Repricing" tab in the RFP workbook.
- Provide a reconciliation that ties your claims repricing back to the total eligible charges provided for each section of the exhibit.

[See "6.1 Claims Repricing" tab in State of CT - July 1, 2026 RFP Attachment File.xlsx]

Single, Radio group.
1: Attached,
2: Not provided

12.6.1.2 Provide an explanation detailing how the claims were repriced, noting any and all adjustments and methodologies.

1000 words.

12.6.1.3 Confirm your re-pricing is based on your current network provider contractual fee arrangements. "Current" is defined as the discounts the State would achieve through your network as of July 1, 2025. The re-priced amounts should reflect what you would have paid a provider if the claim was incurred on July 1, 2025. The repriced amounts should also include any and all fees paid to providers as outlined in the repricing exhibit.

Single, Radio group.
1: Confirmed,
2: Not confirmed

12.6.1.4 Confirm your re-pricing is based on actual data and does not include any assumptions regarding projected discounts or assumed increases in billed charges.

Single, Radio group.
1: Confirmed,
2: Not confirmed

12.6.1.5 Confirm you have not omitted any adjustments or methodologies from your explanation on how you re-priced the claims.

Single, Radio group.
1: Confirmed,
2: Not confirmed

12.6.1.6 Confirm that you have provided the claims reconciliation for all charges provided in the claims file.

Single, Radio group.
1: Confirmed,
2: Not confirmed

12.6.2 Physician Reimbursement

12.6.2.1 **Physician Discount Analysis**. Confirm completion of this spreadsheet for network physicians. Provide your current (as of July 1, 2025) average physician discounts negotiated in Connecticut (all counties/all areas) as well as your average physician negotiated discounts specific to each county in CT. These discount percentages must be based on actual achieved discounts and should not be based on projected or expected discounts. Chart should be copied and completed for each network being proposed. **[See "6.2 Physician Discount" tab in State of CT - July 1, 2026 RFP Attachment File.xlsx]**

DO NOT PROVIDE PROJECTED OR EXPECTED DISCOUNT PERCENTAGES.

Single, Radio group.
1: Attached,
2: Not provided

12.6.2.2 Indicate non-network equivalent Reasonable & Customary Percentile used for non-network reimbursement for the POS/PPO Plan.

Percent.

12.6.2.3 Indicate source of non-network Reasonable & Customary Allowances (Ingenix, Medicare, ADP, Other).

100 words.

12.6.3 Hospital and Outpatient Facility Charges

12.6.3.1 **Hospital Discount Analysis**. Confirm completion of this spreadsheet for network hospitals. Provide your current (as of July 1, 2025) average inpatient and outpatient hospital discount negotiated in Connecticut (all counties/all areas) as well as your average physician negotiated discounts specific to each county in CT. **[See "6.3 Hospital Discount" tab in State of CT - July 1, 2026 RFP Attachment File.xlsx]**

DO NOT PROVIDE PROJECTED OR EXPECTED DISCOUNT PERCENTAGES.

Single, Radio group.
1: Attached,
2: Not provided

12.6.3.2 Describe how network hospitals are reimbursed. Your answer should be consistent with the fees provided on the spreadsheets provided. If reimbursement varies by geographic location, identify reimbursement arrangements by area for those relevant to the plan sponsor. Also note ANY variation in average discounts for larger claims over a certain threshold by identifying the threshold and the impact those contractual arrangements have on the discounts.

1000 words.

12.6.4 Capitation Arrangements

12.6.4.1 Are any of the benefits or services you offer reimbursed through a capitated arrangement? If yes, please list all services that are capitated.

Single, Radio group.
1: Yes, explain: [500 words] ,
2: No

12.6.4.2 For any of the capitated services listed in the prior question, does the State have the option of paying for these services on a fee-for-service basis as opposed to a capitated basis?

Single, Radio group.
1: Yes, explain: [500 words] ,
2: No

12.6.4.3 Confirm that the State will have access to reports which will show the actual fee-for-service claims experience and utilization for any benefits or services that are under a capitated arrangement?

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

12.6.5 Network Access

12.6.5.1 Confirm completion of network disruption analysis. Indicate with a "Y" for Yes and "N" for No whether the Providers (physicians and hospitals) are in your proposed medical network **[See State of CT - July 1, 2026 RFP Network Disruption File.xlsx]**

NOTE: If the same provider is listed multiple times, you must provide a "Y" or "N" response for each individual record on each of the tabs. You cannot make any assumptions, the "Y" or "N" response needs to be specific to that provider, not to a category of providers. Tax ID is included in the Provider Disruption Reports.

Single, Radio group.
1: Attached,
2: Not provided

12.6.5.2 Confirm completion of geographic access analysis. Summarize your network access reports for your proposed medical network for State and Partnership employees separately. If multiple networks are proposed please copy and complete charts for each network. **[See "6.5 Network Access GEO" tab in State of CT - July 1, 2026 RFP Network Disruption File.xlsx]**

Single, Radio group.
1: Attached,
2: Not provided

12.6.6 Uniform Data Submission (UDS) Database Discount Comparison

12.6.6.1 The Uniform Data Submission workgroup is a collaborative effort to reach consensus on the definition of financial terms, claims categories, and general methodology of data files prepared and sent to consulting firms for discount comparison.

Segal receives the data files semi-annually (calendar year and mid-year). The files include 12 months of incurred claims experience for each carrier's entire commercial book of business, including two months of run-out. Capitation, surcharges, and network access fees are excluded.

Segal has developed a proprietary method of analyzing the data that has been approved by all participating carriers. **Please indicate below that you agree to the use of our UDS database in this analysis (action required).**

We acknowledge Segal will use their UDS database to perform a network discount comparison. Segal's results will be validated with each carrier prior to the release of the analysis to the State.

Single, Radio group.
1: Confirmed,
2: Not confirmed

12.6.6.2 To complete our discount analysis using the UDS data, please answer the questions below:

	Response
Which network should be used in the database? Do we need to combine any networks in certain locations? Or use one network for [Region 1] and another for [Region 2]?	*500 words.*
Is there anything outside of the UDS system we should know about?	*1000 words.*
Based on the outcome of this task force, Segal will use UDS data to analyze network discounts as part of our standard methodology to perform a discount analysis. If you are not currently part of the UDS Task Force, would you be willing to provide Segal with data in an agreed upon format on behalf of the State? If yes, please contact us and we will provide the data requirements and record layout.	*1000 words.*

12.6.7 Services and Fees Related to Federal and State Mandates

12.6.7.1 Please confirm (Yes or No) whether you will provide the following services related to federal and state mandates on behalf of the State for all of the benefits/plans outlined in this RFP. For each service, indicate if there is an extra charge for providing this service. Please provide additional comments, if necessary.

	Service Provided	**Fee**	**Additional Comments**
Tracking and reporting member counts for:			
a. CT Pediatric Immunization Fee	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.* N/A OK.	*500 words.*
b. Out-of-State Fees and Surcharges (i.e. NY Surcharge, etc.)	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.* N/A OK.	*500 words.*
Payment on behalf of the State for:			
a. CT Pediatric Immunization Fee	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.* N/A OK.	*500 words.*
b. Out-of-State Fees and Surcharges (i.e. NY Surcharge, etc.)	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.* N/A OK.	*500 words.*

13 Data and Data Sharing Confirmations

13.1 Medical Claims Administration

13.1.1 Confirm your willingness and ability to provide the data and data sharing requirements for the plan as outlined below.

Ref #	Requirement	Confirmation
D1	Monthly detailed claims file to OSC, Segal and Data Warehouse (Merative) including: ·Allowed amounts to providers ·Timely integration of supplemental data ·Files that show provider reimbursement to match to claims ·Other vendors (agreed upon file format)	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D2	Payer must provide daily complete eligibility files to care management provider, and any other partner vendor designated by the State, in either 834 or agreed file layout ·Eligibility supporting material also to support translation of eligibility codes	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D3	·Payer must provide daily complete claim files to care management provider agreed file layout (frequency may be different between medical or pharmacy payers) ·Claims file must provide the complete details of each unique claim journey ·Claim file must provide billed/charged amounts, Plan paid and member paid ·Claim file must provide member and provider level identifiable information i.e. TPAInsuredID, member name / DOB / SSN, or NPI and clinical information, and any additional information to support client servicing/reporting	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D4	Payer must ingest daily authorization files from care management provider in a mutually agreed upon layout	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D5	·Payer must provide API accessibility to member EOBs to care management provider ·API must result in a PDF image to display in member portal and internal systems	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D6	·Payer must provide API accessibility to member ID Cards to care management provider ·API must result in a PDF image to display in member portal and internal systems	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D7	Payer must provide via API or daily data files access to member accumulator information (typically this is through the medical payer which combines medical and pharmacy claim data together)	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D8	·Payer must provide on a monthly or more frequent basis a file including member and provider details to the State's dental carrier in an agreed upon format. This file is	*Compound, Pull-down list.* 1: Confirmed,

	specific to individuals with a pre-determined list of ICD-10 diagnosis codes and is to be used for the dental carrier's Oral Health Integration Program.	2: Not confirmed, explain: [100 words]
D9	Payer must provide on a monthly or more frequent basis aggregate claim financial reporting that will support care management provider reconciliation process	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D10	Payer must provide care management provider with view only access to payer portal to view eligibility and claims information to support membership	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D11	Payer must provide care management provider with direct access to client specific escalation customer service representatives at the payer	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D12	Share the following data with provider groups in the Primary Care Initiative or other risk-based arrangements as applicable: • Claims feeds • Pre-certification data • Attribution of high-risk and at-risk members • Eligibility • GIC Reports • HCC Gap Payor Report (YOY) • MAO-004Medical Claims • MMR • MOR	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D13	Detailed reporting, by data source (i.e. administrative claims, EMR/supplemental data, Connie statewide HIE (panel, Lab, ADT, CCD, etc.) on care quality metric data gap closure	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]

13.2 Member Advocacy

13.2.1 Confirm your willingness and ability to provide the data and data sharing requirements for the plan as outlined below.

Ref #	Requirement	Confirmation
D1	Share the following data with the administrator of the state's value-based care arrangements, including the PCI as applicable: ·Pre-certification data	*Compound, Pull-down list.* 1: Confirmed,

	·Attribution of high-risk and at-risk members ·Eligibility ·GIC Reports ·HCC Gap Payor Report (YOY) ·MAO-004 ·Medical Claims ·MMR ·MOR	2: Not confirmed, explain: [100 words]
D2	·Primary Care designation with Medical and PCI administrator	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D3	·Utilization Management files with medical claims payer (nightly)	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]

13.3 Primary Care Initiative

13.3.1 Confirm your willingness and ability to provide the data and data sharing requirements for the plan as outlined below.

Ref #	Requirement	Confirmation
D1	·Must commit to ingest data from the state's HIE - CONNIE and incorporate data into the measurement of provider performance eon quality metrics - monthly	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D2	·Must commit to ingest supplemental data feeds from providers and incorporate data into the measurement of provider performance eon quality metrics - monthly	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D3	·Direct access for state staff to real-time quality and financial reporting	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D4	Medical and pharmacy claims data is made available to groups through administrator's population health data tools and through direct full claims feeds	*Compound, Pull-down list.* 1: Confirmed,

		2: Not confirmed, explain: [100 words]
D5	·Deliver real-time financial and quality reporting to provider groups through provider portal	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D6	·Must be able to ingest and share with providers the following data feeds ·Claims feeds ·Pre-certification data ·Attribution of high-risk and at-risk members ·Eligibility ·GIC Reports ·HCC Gap Payor Report (YOY) ·MAO-004 ·Medical Claims ·MMR ·MOR ·Pharmacy Claims	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
D7	Ensure all program reporting is fully automated and integrated into population health tools accessible by OSC and participating provider groups by July 1, 2026	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]

14 Performance Guarantees

The State will focus on three areas of performance guarantees as part of this RFP: trend, quality, and service. There will be downside and upside risk for each guarantee with a cumulative total of all three. The structure of the guarantees will put the vendor at risk for up to 70% of administrative fees for missed guarantees. The vendor will also have the ability to earn additional "bonus" fees up to 35% of the administrative fees if they exceed expectations in any or all of the three areas. Details regarding the performance guarantees can be found below and there is a sample model of the performance guarantee structure for payment and earnings in the performance guarantee file. **[See State of CT - July 1, 2026 RFP Performance Guarantees.xlsx]**

In addition to the focus areas mentioned above, there will also be operational guarantees with itemized amounts up to a maximum of 5% of administrative fees at risk.

In total the vendor will be at risk for up to 75% of administrative fees and have the ability to earn a bonus of up to 35% of administrative fees when reviewing the performance related to trend, quality, service and operations of the plan.

Aligning the financial incentives of the State's vendors with the priorities of the State employee health and Partnership plan is a primary goal of this RFP. All respondents are expected to respond to this section and

commit to placing their administrative fees at risk for all offered services. Please note each service guarantee will be calculated independently, allowing vendors to offset risk in one category with positive performance in another. Significant caveats and limitations will not be accepted. For the Primary Care Initiative Administration the trend guarantees will be applicable to members attributed to participating provider groups only and the NPS score will be measured by provider group survey responses rather than members. In every other category the trend, quality and service guarantees will be applied against the entirety of the enrolled population.

The performance guarantees may be subject to verification by audit.

14.1 Trend Guarantee

14.1.1 The trend guarantee for the plan will be based on the results of the 2025 State of Connecticut healthcare cost growth benchmark of 2.8%. The target trend for year 1 will be 5% when comparing plan year beginning (PYB) July 1, 2026 costs to PYB July 1, 2025 costs. There are step downs in the trend guarantee each year of the contract, with the target of 4.5% in PYB 2027 and 4.0% in PYB 2028. In PYB 2026 and 2027, there will be a 1% risk corridor prior to eligible payments or bonus dollars. In PYB 2028 the vendor will be expected to reach the healthcare cost growth benchmark of 2.8% for bonus dollars to be paid.

The maximum risk sharing for the trend guarantee will be up to 50% of administrative fees back to the State for trend above the annual target and a maximum bonus up to 25% of administrative fees to the vendor for trend below the annual target.

The Trend Guarantee will be based on the following methodology:

1. The trend guarantee will apply to all claims incurred through all medical plans administered by the selected carrier for all participants (active, retiree and Partnership plans).
2. For each year of the contract, the actual plan year incurred claims number will be measured using medical claims that were incurred during the plan year and paid during that plan year plus a six-month run-out period. This total will be divided by the actual enrollment during the plan year.
3. When measuring the trend for the PYB 2026, the actual PYB 2025 incurred claims number will be measured using medical claims that were incurred during the PYB 2025 plan year and paid during that plan year through December 2026. This total will be divided by the actual enrollment during the policy year. All the necessary supporting claims and enrollment data for the PYB 2025 plan year will be obtained by the State from its current medical administrator.
4. Claims will include the amounts that are the responsibility of both the member and the plan (allowed amount) to mitigate distortions created by plan design changes.
5. Claims will include any and all payments associated with the claim, including but not limited to inter-plan network fees, host plan access fees, percent of savings fees, etc.
6. Claims will also include any and all payments made to providers for attribution, provider incentive programs, bonus payments, etc. from vendor programs. (Trend calculation will exclude any State directed programs)
7. The actual PYB 2026 trend will be calculated by dividing the adjusted PYB 2026 incurred claims per member per month (calculated as described above) by the adjusted PYB 2025 incurred claims per member per month (calculated as described above) less 1. (Same methodology applies for PYB 2027 over PYB 2026 and for PYB 2028 over PYB 2027.)

Confirm acceptance of Trend Guarantee as described above and modeled in format requested in **State of CT - July 1, 2026 RFP Performance Guarantees.xlsx.**

Attached Document(s): State of CT - July 1, 2026 RFP Performance Guarantees(10168130.2).xlsx

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

14.2 Quality Guarantee

14.2.1 The quality guarantee for the plan in each year of the contract will be based on the Quality Council Aligned Measure Set as outlined by the Connecticut Office of Health Strategy. The benchmarks can be found here: Aligned Measure Set. The Quality Council Aligned Measure Set is updated annually and the guarantees will be based on the updated set each year of the contract. The target quality metric will be 56% - 65% of OHS quality metrics with improvement or benchmarks met.

The maximum risk sharing for the quality guarantee will be up to 10% of administrative fees back to the State with payback beginning when vendor meets metrics of less than or equal to 55%. The maximum bonus will be up to 5% of administrative fees to the vendor with bonus beginning when vendor meets metrics greater than or equal to 66%.

Confirm acceptance of Quality Guarantee in format requested in **State of CT - July 1, 2026 RFP Performance Guarantees.xlsx.**

Attached Document(s): State of CT - July 1, 2026 RFP Performance Guarantees(10168130.2).xlsx

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

14.3 Service Guarantee

14.3.1 The service guarantee for the plan in each year of the contract will be based on an independent survey of all participating employees conducted by the State to determine the Net Promoter Score (NPS) of each vendor. The target NPS will be 60.

The maximum risk sharing for the service guarantee will be up to 10% of administrative fees back to the State for NPS less than 60 and a maximum bonus up to 5% of administrative fees to the vendor for NPS greater than 70.

Confirm acceptance of Service Guarantee in format requested in **State of CT - July 1, 2026 RFP Performance Guarantees.xlsx.**

Attached Document(s): State of CT - July 1, 2026 RFP Performance Guarantees(10168130.2).xlsx

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

14.4 Operational Guarantees

14.4.1 The operational guarantees for the plan are outlined below. The operational guarantees reflect itemized fees at risk with a maximum at risk of 5% of administrative fees.

Confirm the operational guarantees listed in the chart below.

Ref #	Category	Guarantee	At Risk	Confirmation
O1	Implementation Timeline	A minimum of 95% of all tasks will be completed by the dates specified in the implementation plan agreed to by the Parties. The Implementation plan will be developed by Vendor and will contain tasks to be completed by the State and Vendor and a timeframe for completion of each task. The Implementation plan will also contain Measurement Periods specific to each task. Vendor's payment under this Guarantee is conditioned upon the State's completion of all designated tasks by the dates specified in the implementation plan.	$25,000	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
O2	Open Enrollment ID Card Issuance	100% of ID cards will be mailed to Open Enrollment participants no later than June 15, 2026 provided that Vendor receives an accurate eligibility file by June 1, 2026.	$25,000	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
O3	Claims Timeliness (14 Calendar Days)	This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of Non-investigated Claims. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter, Claims for the State when the State requests changes to Plan benefits, until all such changes have been implemented.	2.5% of Base Admin. Services Fees 94.0% or Greater: None 88.0% to 89.9%: 25% 86.0% to 87.9%: 50% 85.0% to 85.9%: 75% Less than 85.0%: 100%	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]

		This will be measured with State specific Data.		
O4	Claims Timeliness (30 Calendar Days)	A minimum of 98% of Non-investigated medical Claims will be processed timely. Non-investigated Claims are defined as medical Claims that process through the system without the need to obtain additional information from the Provider, Subscriber or other external sources. Processed Timely is defined as Non-investigated medical Claims that have been adjudicated within 30 calendar days of receipt. This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of Non-investigated Claims. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter, Claims for the State when the State requests changes to Plan benefits, until all such changes have been implemented. This will be measured with State specific Data.	2.5% of Base Admin. Services Fees 98.0% or Greater: None 96.0% to 97.9%: 25% 95.0% to 95.9%: 50% 94.0% to 94.9%: 75% Less than 94.0%: 100%	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
O5	Accuracy of File Transmission to vendors	A minimum of 98% of Medical Claims File Transmission of eligibility files, authorizations, claims reports, enrollment data, billing / payments by plan with vendors to be accurate at the time of transmission. Requires automated notification of file transmission failure to load entire file and remediation within 48 hours. An error is defined as a full file transmission that either did not load and/or contained inaccurate date based upon the date of transmission. This Guarantee will be based on the number of File transmission to vendors errors and/or	2.5% of Base Admin. Services Fees 98.0% or Greater: None 97.0% to 97.9%: 25% 96.0% to 96.9%: 50% 95.0% to 95.9%: 75% Less than 95.0%: 100%	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]

		full transmission file error not rectified within 48 hours by the Bidder divided by the total number of File Transmissions to vendors.		
O6	Claims Processing Accuracy / Network Provider Directory Management	97% of audited Clean Claims finalized accurately. Processing errors shall not include errors made in reasonable reliance upon the information provided by the State, its designees or vendors, participants or providers of service in connection with a claims. Clean Claims accuracy is measured by comparing the total number of claims paid or denied without errors to the total number of claims reviewed for the claims administration unit. This will result in the percentage of claims paid accurately. Errors shall include: 1. Claim paid for the incorrect amount. 2. Claim rejected when it should have paid. 3. Claim paid when it should have rejected. 4. Claim did not process in accordance with contract benefits as of the date of the claim processed.	1.25% of Admin Fee 97.0% or Greater: None 96.0% to 96.99%: 25% 95.0% to 95.99%: 50% 94.0% to 94.99%: 75% Less than 94.0%: 100%	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
O7	Financial Accuracy of Claims processed	99.5% of audited Clean Claim dollars finalized accurately; (vs. amount should have paid). Financial errors shall not include errors made in reasonable reliance upon the information provided by the State, its designees or vendors, participant or providers of services in connection with a claim. Processing errs shall not include errors made in reasonable relance upon the information provided by the State, designee or vendors, participants or providers of services in connect with a claim. Clean Claims financial accuracy is measured by diving the total dollar amount of all correctly paid by the total dollar amount that should have paid for all claims in the sample. Financial errors shall include, but are not limited to: 1. Incorrect application of deductible and co-payments.	1.25% of Admin Fee 99.0% or Greater: None 98.0% to 98.99%: 25% 97.0% to 97.99%: 50% 96.0% to 96.99%: 75% Less than 96.0%: 100%	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]

		2. Payment for non-covered services under the Plans. 3. Overpayment of covered services under the Plans. 4. Failure to apply or incorrect application of any coordination of benefits provisions of the Plans. 5. Duplicate payments. 6. Incorrect application of limits.		
O8	Network Changes	Provider services within outlined regions to ensure coverage for all State employees and must be access to accepting new patients. Changes must be communicated at least 30 calendar days in advance or within 3 calendar days of notification by the provider to Vendor, whichever is less. A significant change is defined as a reduction in network that would leave any region with less than two (2) choices that are accepting new patients in both INN and OON choices. This will be measured with State specific Data.	$2,000 per occurrence for any region with less than 2 choices in both INN and OON that are accepting new patients; AND $2,000 per occurrence for lack of communication of changes.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
O9	Appeal Turnover	A minimum of 25% of medical claims appeals; first level and second level appeals to be overturned by the State following the Vendor's denial of claim based upon the Plan and a complete review of the medical claims history which includes prior authorizations (i.e., a Member's diagnosis from medical claims where diagnoses are required). This Guarantee will be based on the number of appeals the State approves following the denied claim by the Vendor divided by the total number of appeals overturned by the State. This will be measured with State specific Data.	1.5% of Base Admin. Services Fees 99.0% or Greater: None 97.9% to 98.9%: 25% 95.0% to 96.9%: 50% 93.0% to 94.9%: 75% Less than 93.0%: 100%	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]

O10	Network minimum size and growth (behavioral health)	Provider services within outlined regions to increase coverage in Behavioral Health providers that are accepting new patients for all State employees. The initial established network would be determined during implementation and serve as the baseline for all calculations. Changes must be communicated at least 30 calendar days in advance or within 3 calendar days of notification by the provider to Vendor, whichever is less. • Initial behavioral health appointment within 5 business days (target: ≥ 95%) • Crisis appointment available within 24 hours • 95% of members have at least 2 in-network providers within 10 miles that are accepting new patients. This will be measured with State specific Data.	1.5% of Base Admin. Services Fees 5.0% or Greater: None 4.0% to 4.9%: 25% 3.0% to 3.9%: 50% 2.0% to 2.9%: 75% Less than 1.0%: 100%	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
O11	Account Management Response time	Vendor will provide complete response to the State on escalated member / provider issues within 24 hours of the request unless otherwise mutually agreed upon. Vendor will provide notification of systemic issues where claims are not processed and/or paid correctly with 72 hours of Vendor's identification of issue. Vendor must provide monthly reporting to the State of all escalations with status details and estimated date of resolution. This will be measured with State specific Data.	$2,500 per occurrence of lack of response; AND $2,500 per occurrence of missing the monthly status reporting.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
O12	Benefit Change Management	Timely and accurate Implementation of all programs and program changes required by the State after year one, based upon	$5,000 at risk per program or program change.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed,

		mutually agreed upon implementation deadline. This will be measured with State specific Data.		explain: [100 words]
O13	Data Transmission on new programs or program changes.	Timely file transmission for all new programs and program changes required by the State after year one within 60 days of State signoff on requirements.	$2,500 per occurrence	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
O14	Eligibility Management with State and Other Vendor Partners	99% of eligibility updates received from the State processed within forty-eight (48) hours of receipt of a clean and complete eligibility file in an agreed upon format. 99% of the eligibility updates are transmitted to the vendors within 72 hours of receipt of a clean and complete eligibility file from the State. This guarantee metric applies to systematic records and excludes records that fall out for manual review. This will be measured with State specific Data.	1.25% of Admin Fee 98.0% to 100% | None 97.0% to 97.99% | 25% 96.0% to 96.99% | 50% 94.0% to 95.99% | 75% Less than 94.0% | 100%	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]
O15	Eligibility Reconciliation	By the first business day of each month, Comptroller will provide the Contractor with a HIPAA compliant reconciliation full file, which includes all State-specific fields. This format is utilized to balance participation from State records to the records of the Contractor on a monthly basis. Measured by Contractor's ability to provide, by the first business day of each month, consistent and accurate reporting.	1.0% of Admin Fee Miss 5th Business day: None Miss 5th Business day 2x: 25% Miss 5th Business day 3x: 50% Miss 5th Business day 4x: 100%	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed, explain: [100 words]

15 Bid Exceptions/Deviations

15.1 Completion of this proposal confirms authorization of your ability to duplicate requested services and administrative arrangements. If you are unable to meet ALL requirements and/or are not able to fully comply with the specifications in this Request for Proposal (RFP), please list ALL explanations, limitations, exceptions, and deviations in the attached.

Single, Radio group.
1: Completed and attached,
2: No deviations

Attached Document(s): RFP Attachment A - Bid Exceptions and Deviations Form(10171332.1).docx