OFFICE *of the* STATE COMPTROLLER

RFP Medical Claims Administration, Member Advocacy, PCI Administration, and MEHIP Claim Administration

Respondent Questions & Answers – August 2025

Question 1: Are we required to Bid on the MEHIP?

Response: No, bidders are not required to submit a proposal for the MEHIP and the RFP for administration of the MEHIP will be released separately in the near future.

Question 2: Regarding: 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 Question: Can job descriptions of each position be provided? Are these roles filled by the current Admin or State Of Connecticut employees? Are these positions onsite or via telecommunication?

Response: These roles are filled by the current administrator and are not onsite at the State.

Question 3: Regarding: 7.1.8 Are you willing to delegate all utilization management responsibilities, including J-code authorizations to a designated care management or advocacy vendor? Question: Do you currently work with an advocacy vendor and if so what is the name? It is noted that the HEP program is administered by Quantum Health, do they also do the UM/CM currently?

Response: Yes, Quantum Health currently performs the UM/CM for all medical services except for mental/behavioral health and medical pharmacy.

Question 4: Please provide a count list of Pre-certifications handled in 2024 plus a count list by Medical Major Condition (Oncology, Transplant, Respiratory, Diabetes, Behavioral Health, etc.) for Case Management.

Response:
In 2024, a total of 184,726 pre-certifications were handled. The distribution by authorization status is as follows:

Authorization Status	Count
Approved	169,751
Non-Certification	2,010

Authorization Status	Count
Pending	209
Withdrawn	12,756
Grand Total	**184,726**

Breakdown of Approved Authorizations by Major Medical Conditions

Focusing on **approved** authorizations in 2024, the following provides a summary by key medical conditions relevant to case management (e.g., oncology, transplants, respiratory, and diabetes):

- **Oncology**: 9,350 approved authorizations (encompassing all cancer treatments).
- **Transplants**: 121 approved authorizations.
- **Respiratory**: 117 approved authorizations.
- **Diabetes**: 44 approved authorizations.

Question 5: Is the model in the Primary Care Initiative as outlined an example of an initiative and is there any flexibility in what model is implemented or is that the model to be implemented?

Response: Bidders should replicate the current model with the understanding that the State is also open to suggestions for enhancements etc.

Question 6: What is the current out of network arrangement? Is the current vendor charging a % savings? If so, what is the %?

Response: The current out-of-network arrangement is that the plan pays 80% UCR for facilities, 200% of UCR for professional services. The vendor does not charge a percentage of savings.

Question 7: The sample contract provided requires all call center and customer service work to be completed within the State of CT, is this requirement mandatory?

Contract Language: Contractor shall perform all required state business-related call center and customer service work entirely within the State of Connecticut. If Contractor performs work outside of the State and adds customer service employees who will perform work pursuant to this Agreement, then Contractor shall employ such new employees within the State prior to any such employee performing any work pursuant to this Agreement.

Response: The language referenced is applicable to services available to the general public. The services in this RFP are specific to public employees of the State of CT or CT Partnership plan, therefore, it is not applicable.

Question 8: Is MEHIP included in the census or is it separate

Response: MEHIP is not included in the census.

Question 9: Can we offer tiered fees? Can we win slice State/Partnership?

Response: The State and Partnership must be bid as one group.

Question 10: Are there any specific concerns that are bringing this opportunity out to bid?

Response: The State is required to go out to bid for Medical ASO every 5 years.

Question 11: What percentage share of the medical/Rx rebates are retained by the State

Response: The State requires 100% pass through rebates.

Question 12: How many dedicated carrier FTE's are currently working on the State in total?

Response:
Claims Administrator- Account support/service and eligibility: there are 12 dedicated associates. In addition, in other areas of operations such as Reporting, Underwriting, ASO Billing, Finance, Appeals, Vendor Solution Support, BH CM/UM, there are 35 designated associates who are identified to support the State.

Advocacy-

- POD team: 65 (inclusive of Manager, Member Experience Leads, PSR)
- HEP Support: 2
- HEP Incentive Management: 1
- Account Team: 3
- Clinical: 1
- Peripheral supporting clinical 26 (they don't solely support the State)

13: We have a pressing question regarding the collusion clauses included in the RFP. The response to this question is critical to our proposal response.

RFP Collusion Provisions
Regarding Section 4 Proposal Requirements subsections 13 and 21, subsection 13 prohibits communications with employees of the OSC or members of the HCCCC or their *representatives and bidding partners regarding their proposal*. Section 21 states *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.*

Some of the presumed bidding contractors are also our preferred vendors. We are requesting written clarification to determine if we are allowed to work with our preferred vendors to provide an integrated proposal.

While we do not discuss their proposals or pricing when working on RFPs, by providing answers to RFP questions and bidder specific pricing, our preferred vendors would have specific knowledge of the responses they provided for the RFP, which would put us out of compliance with these provisions.

We need clarification on this matter as soon as possible please. Thank you!

Response: We understand that you may want to partner with other entities who already partner with the State and it would require communication. These partnerships to fulfill the requirements of the RFP are encouraged.

Question 14: Can you provide a summary plan description document if not provided already?

Response: All of the plan documents can be found here**:** https://carecompass.ct.gov/

Question 15: Is it possible to receive a copy of the contract the State of CT has with the current medical vendor?

Response: A redacted version is available upon request.

Question 16: Will current administrative fees be provided?

Response: This information will not be provided.

Question 17: The RFP mentions a multitude of external vendors, what is the expectation for integration with current vendors?
Effective integration with claims processors, care management, disease management, and PBM vendors to ensure coordinated oversight.

Response: The State expects integration with all current and potential vendors as needed to effectively administer the health plan.

Question 18: How is coordination of benefits handled with the current medical vendor? Is there a % of savings being charged?

Response: The current medical vendor manages COB. No, there is not a percentage of savings being charged.

Question 19: Page 15 of the RFP makes specific mention of pre-adjudication audits. Please provide in detail what the State is hoping to accomplish as a result of these audits.

Response: The goal of the pre-adjudication audit is to prevent payment errors before they happen and to ensure that the claims administrator is processing claims according to the benefit intent of the plan.

Question 20: Provide detail of any services/fees that are currently charged through the claim wire other than capitation?

Response: There are no other services or fees currently charged through the claim wire.

Question 21: Please confirm how enrollment is handled today, and what tools are used. Is the State looking for an open enrollment tool as part of this bid process?

Response: For the State plan, enrollment is decentralized and handled by each employing state agency. The State uses the Core-CT (PeopleSoft) system to process and store enrollment data. The State uses the PeopleSoft e-Benefits module for employee enrollment; however, many agencies continue to use Core-CT-generated enrollment forms and manually enter

employee coverage elections. Enrollment information is transmitted to the medical carrier weekly, and a full eligibility file is sent monthly to be used as a comparison file. The medical carrier provides enrollment data to the pharmacy and advocacy vendors.

Depending on the size of the group, the Partnership plan groups use online enrollment or their own eligibility system and transmit an 834 file.

Although it is not a requirement, the state welcomes bids that include an intuitive and user-friendly enrollment tool for open enrollment and/or all employee benefit enrollment transactions.

Question 22: Is online enrollment and plan selection support only needed during open enrollment? If not, please provide an example.

Response: The advocacy/member services vendor should provide online enrollment and plan selection support during the plan year, not just during open enrollment. An example would be a new hire who is trying to decide what plan to enroll in and has questions about the plans or the e-Benefits process.

Question 23: Please provide details of the level of support requested for open enrollment meeting

Response: Full support for virtual and in-person meetings is expected. The selected vendor will be the primary source for answering employee benefit questions during all open enrollment events.

Question 24: Is dental claim administration included in this bid process?

Response: The dental plan is not included in this bid. Dental is fully insured through Cigna.

Question 25: Regarding the financial model within the Primary Care Initiative [pay for performance], who is responsible for monitoring and reporting?

Response: The Administrator is responsible for monitoring and reporting.

Question 26: Are any of the current networks state-created (proprietary) networks or are they all Anthem?

Response: They are all Anthem networks.

Question 27: How many non-bargained employees are eligible to participate in a customized high-performance network plan?

Response: All State employees (bargained and non-bargained) have the option to participate in a customized high-performance plan. The plan is voluntary, and the design is not bargained as part of the SEBAC agreement.

Question 28: Will the entire RFP and network analysis be submitted through ProposalTech or will some need to be submitted through CTsource Bid Board noted in section 4.3?

Response: This will all be submitted through ProposalTech.

Question 29: Define the pre-adjudication audit capabilities expected [section 7.3.2]?

Response: A pre-adjudication audit requires complete claim and medical documentation, adherence to coding and policy rules, eligibility/provider verification, a structured audit workflow, and reporting for transparency and improvement.

Question 30. Question 7.3.15 - Does the hold harmless language assume the right of the bidder to recover overpayment or duplicate payment errors from the patient or provider?

Response: The hold harmless language requires that the State be held harmless from a firm's payment processing errors. The question is beyond the scope of the RFP question in this subject matter.

Question 31: Question 7.4.3 - Does the hold harmless language assume the right of the bidder to recover COB payment errors from the patient or provider?

Response: The question is beyond the scope of the RFP question in this subject matter.

Question 32: For question 7.17.2 Are claims funded by Anthem and reimbursed by the State twice per month?

Response: Yes.

Question 33: Question 7.16.13 indicates the right to audit post-term for two years, but the agreement says three. What is the number of years post-term requested for audits?

Response: Three

Question 34: Specifically to the Partnership Plan, will we receive a consolidated eligibility file?

Response: The Partnership Plan eligibility file is broken out by employer group and further reflects each group's preferred structure (sub-groups by bargaining unit etc.).

Question 35: Please confirm if the OOP RX is combined with the OOP medical.

Response: The OOP Rx is not combined with the OOP medical, they are separate.

Question 36: Specifically to the Partnership Plan, will we need to report each enrolled group separately and aggregately?

Response: Yes, this is a requirement.

Question 37: What is the percentage or average number of non-compliant HEP members per year?

Response: The HEP non-compliance rate has averaged approximately 3% for many years.

Question 38: What percent of membership is in the Expanded Access POS Plan (POS)?

Response: 37%

Question 39: What percent of membership is in the Standard Access Point of Enrollment (POE)?

Response: 41%

Question 40: What percent of membership is in the Primary Care Select Access (POE-Plus)?

Response: 7%

Question 41: Does Quantum manage the member and provider portals for all benefits/programs?

Response: The State manages CareCompass.ct.gov. Members can access the Quantum portal on CareCompass, which includes SSO access to other vendors.

Question 42: How many employees are dedicated to servicing the State of CT?

Response:
Claims Administrator- Account support/service and eligibility: there are 12 dedicated associates. In addition, in other areas of operations such as Reporting, Underwriting, ASO Billing, Finance, Appeals, Vendor Solution Support, BH CM/UM, there are 35 designated associates who are identified to support the State.

Advocacy-

- POD team: 65 (inclusive of Manager, Member Experience Leads, PSR)
- HEP Support: 2
- HEP Incentive Management: 1
- Account Team: 3
- Clinical: 1
- Peripheral supporting clinical 26 (they don't solely support the State)

Question 43: Are there any customer service employees housed at State facilities to serve members?

Response: Today, we have two advocacy account team members in the state office. The State will consider any proposal to include additional on-site customer service staff.

Question 44: Providers of Distinction - Does Embold provide Anthem the eligible incentive, or does Anthem track utilization of these providers and pay the member directly?

Response: Embold administers the Provider of Distinction program and handles the incentive process.

Question 45: Is Vision administered by the medical carrier?

Response: Routine vision exams are administered by the medical carrier. The Vision Rider (only offered to Partnership groups) is administered by CIGNA.

Question 46: Is prior authorization performed by Anthem or Quantum?

Response: All prior authorization except for Mental Health and Medical Pharmacy is currently being performed by Quantum.

Question 47: What was 2024 spend?

Response: Twenty-four months of monthly enrollment and claims through May 2025 for the State and Partnership plans was provided in the file: State of CT - July 1 2026 RFP Census and Claim Data. In addition, utilization data can be found here in the public reports recently posted to Proposal Tech.

Question 48: What was 2024 enrollment?

Response: See response to question 47

Question 49: What is 2025 spend?

Response: See response to question 47

Question 50: What is 2025 enrollment averaging?

Response: See response to question 47

Question 51: Health Enhancement Plan
a. It states that employees can opt out at any time; their credit is prorated based on the service(s) provided. Can you provide an example of a single employee who meets partial requirements?
b. How is the administrator notified of HEP non-compliant members, and when does the higher premium as well as the higher deductible/medical copay/RX copays get applied?

Response:
a. Employees can opt out of HEP when they are initially hired or during open enrollment. HEP compliance is based on full completion of requirements, not partial.
b. The HEP administrator notifies the State and each partnership group of the non-compliant members. Penalties are generally applied on August 1st for the prior calendar year. For example, employees or households non-compliant for 2024 HEP requirements are penalized on 8/1/2025.

Question 52:
a. Confirm Year 1 trend guarantee of 5% (includes 1% risk corridor) commences on 7/1/2026, includes claims with a 2026 date of service paid through 12/31/2027 with payout in 2028?

b. Confirm Year 2 trend guarantee of 4.5% commences on 7/1/2027, includes claims with a 2027 date of service paid through 12/31/2028 with payout in 2029?

c. Confirm Year 3 trend guarantee of 4.0% commences on 7/1/2028, includes claims with a 2028 date of service paid through 12/31/2029 with payout in 2030?

Response: Confirmation of trend guarantee terms:

a. Year 1 trend guarantee of 5% (with 1% risk corridor) based on claims incurred July 1, 2026 through June 30, 2027 and paid July 1, 2026 through December 31, 2027. The payout based on terms of the guarantee by June 30, 2028.
b. Year 2 trend guarantee of 4.5% (with 1% risk corridor) based on claims incurred July 1, 2027 through June 30, 2028 and paid July 1, 2027 through December 31, 2028. The payout based on terms of the guarantee by June 30, 2029.
c. Year 3 trend guarantee of 4.0% (with 1% risk corridor for payment by vendor to State and 1.2% corridor for bonus payment by State to vendor) based on claims incurred July 1, 2028 through June 30, 2029 and paid July 1, 2028 through December 31, 2029. The payout based on terms of the guarantee by June 30, 2030.

Question 53: Agreement Section C says the Comptroller can terminate the agreement if they unilaterally determine it is no longer in the best interests of the State. Will the ability to cure breaches will also apply to this "best interests" determination?

Response: At the discretion of the State

Question 54: Agreement Section C - State reserves right to, in response to breach or violation of reps and warranties, rescind the agreement without any liability. Is the intention of this section that the bidder would not be paid for work performed at the time of this termination.

Response: No, the State will reimburse Contractor for its Performance rendered and accepted by the Comptroller in addition to all actual and reasonable costs incurred after Termination in completing those portions of the Performance which the notice required Contractor to complete.

Question 55: Agreement Section F.7.a. - Bidder would be required to indemnify the state for claims arising out of or related to ANY act or omission. Is there a standard of care definition that can work in conjunction with this

Response: The State is open to negotiation on the standard of care definition.

Question 56: Agreement Section F.9.a.-b.indicate that the bidder and subcontractors must agree to onsite inspection and audit within 24 hours' notice. Are these 24 business hours?

Response: The general timeframe is one business day.

Question 57: Section F.10 says the bidder must maintain insurance for premiums, taxes, audits, commissions, policy deductibles and self-insured retentions. Please confirm what type of coverages are being referenced in this section.

Response: Commercial General Liability, Automobile Liability, Workers' Compensation and Employer's Liability, Umbrella Liability, Professional Liability and Information Security Privacy/Cyber Security Liability

Question 58: Please confirm what "technology services or technology products" listed in the Agreement Section F.10.f includes.

Response: "Technology services or technology products" includes but is not limited to the use of the State's enterprise software system, the use of any of the State's individual software programs or platforms, and any of the State's technological infrastructure or hardware.

Question 59: Agreement Sections G.3.B.ii and G.3.B iii requires posting of notices for labor union employees. Does this apply only to State of Connecticut employees?

Response: If Contractor's performance affects State of Connecticut employees who are members of labor unions, then Contractor must post notices in accordance with the Agreement.

Question 60: Agreement Section G.5. requires posting of a whistleblower notice. Does this apply only to State of Connecticut employees?

Response: No. See C.G.S. Sec. 4-61dd *et seq.* for details.

Question 61: To confirm - RFP Attachment B - Standard HPBSD Contract May 2025 is for reference only? The State does not need a legal review at this time?

Response: Please note your preliminary exceptions in the bid exceptions and deviations document.

Question 62: Is the state open to considering the integration of a virtual primary care component into the navigation response? Both to enhance the member experience as well as to potentially provide another high-quality primary care option that aligns with your PCI initiatives?

Response: OSC is open to learning more about offerings from vendors that have the potential to improve the SOCT health plan member experience, however this RFP specifically seeks a vendor that can successfully manage the SOCT PCI as currently structured and be willing to support necessary program design modifications that align with the OSC's statutory obligations.

Question 63: Provider Quality: Would the state consider leveraging embedded provider quality tools outside of Embold or is the intent for Embold to remain in place regardless of navigator selection?

Response: Embold is subcontracted under the State's current navigation vendor Quantum and therefore could be replaced through the RFP process, however the State reserves the right to retain Embold as vendor for these services if it is in the best interests of the State regardless of the outcome of the navigation vendor award.

Question 64: PCI:
a) Can you share whether providers are added or removed from the PCI designation. If so, how frequently and how is this communicated to vendors?
b) Can you share what data exchange and reporting expectations are in place for the navigation vendor as it pertains to the PCI initiative

Response:
a) Providers are not "designated" into the Primary Care Initiative (PCI). Instead, any primary care group that meets the eligibility criteria can choose to join by signing a participation agreement through the program's vendor. Because it's a contractual value-based care arrangement, groups are not added or removed by the program itself. Instead, participation depends on whether a practice elects to join or no longer meets the eligibility requirements. If there are changes in participation, those updates are managed through the vendor contract process as part of ongoing program operations.

b) The PCI is a total cost of care model that uses medical and pharmacy experience as well as clinical data from the Connie statewide Health Information Exchange and supplemental clinical data directly from PCI provider groups. These data allow for detailed reporting for attributed PCI

population that include total cost of care, quality measurement, improved care coordination opportunities.

Question 65: Is the state able to share current member services (incumbent navigator/carrier) call/chat annual volume, % digital interactions vs calls as well as Care, case and disease management annual case volume?

Response: Average number of member calls for 2024 was 14,000 per month, average number of provider calls was 9,000 per month. In 2024 there were approximately 118,000 Care Coordination and Clinical Support interventions.

Question 66: Utilization Management (UM):
a) Given the varying set of services related to UM (such as provider benefits and eligibility verification, decision approvals/denials, appeals) can you confirm the UM services currently in place with the incumbent navigator and if the state is open to exploring alternative UM approaches.
b) Can the state share the current UM pre-certification list

Response: Yes, the State would consider alternative approaches but is mindful of ensuring value and appropriate access in determining utilization management strategies.

Current UM pre-certification list.

- Attached list of CPT codes –
- Air and water ambulance (if non-emergent)
- Inpatient and Skilled Nursing admissions
- DME over $1500 and all rentals
- Chemo
- Radiation Therapy
- PT and OT
- Outpatient Surgeries
- Private Duty Nursing
- MRI, MRA, & Pet Scans
- Organ, Tissue and Bone Marrow Transplants
- Inpatient Hospice
- Sleep Studies
- Genetic Testing
- Partial Hospitalization and Intensive Outpatient for Mental Health/Substance Abuse
- Specialty meds administered in office, outpatient or home

Question 67: Can you share whether union codes are present on the eligibility file and how many individual union codes there are?

Response: No, the union codes are not on the eligibility file.

Question 68: Primary Care Select Access “POE-Plus” plan:
a) How are members today electing/changing a PCP (portal, phone call, etc)?
b) Are members able to elect both brick & mortar and virtual primary care physicians?

c) What happens if a member sees a non-attributed PCP or does not get an authorized referral prior to service?
d) Can you share the expected division of responsibilities on the POE-Plus plan between the TPA and Advocacy vendors? Is the expectation that the advocacy vendor will support members on this plan (ex- owning provider referral submissions and managing members that are electing/changing their PCP?).
e) If the current and/or expected member experience is for the advocacy vendor to fully support members on this plan, can you share whether a data file or log in supporting PCP changes or provider referral needs can be provided to the navigation vendor from the carrier or additional details as to how it is managed currently?

Response:
a. Upon enrollment, a PCP is assigned to the member based on zip code. An employee can change the assigned PCP by calling member services.
b. No, the plan does allow virtual PCP assignments at this time.
c. It the member does not get and authorized referral from a participating PCP the claim is denied
d. The advocacy vendor should manage the PCP process and member support.
e. Yes, a data file should be shared with the navigation vendor.

Question 69: Is Care Compass a white-label solution, or can it be co-branded with our solution?

Response: No, Care Compass is not a white-label solution. “Care Compass” was developed internally and is used as cobranding with our underlying vendors, carriers, and point solutions.

Question 70: For the Quality First Select Access network- can you please share the % of providers that are currently in tier 1 vs tier 2? Do you expect this to change drastically?
For the Quality First Select Access network- are there any specialties/types of care carved out of the tiering? Said another way, is there a provider type/category that are all considered tier 1? Eg. urgent care, emergency department, talk therapy, psychiatry, etc. where all providers are treated as tier 1

Response: There are specialties and services that are not tiered. When a service is not tiered the preferred lower-level copay applies

Question 71: Innovation Plan: What percentage of the total plan membership (Core + Partnership) would be eligible for this plan?
a. Is there any flexibility in allowing the Innovation plan bidder to administer pharmacy benefits?
b. Or is the current PBM required to administer the pharmacy for the innovation plan?

Response: All membership is eligible for the innovation plan, but for Partnership the plan would only be offered as a full replacement. The state could consider a carve-out but it would require strong justification in terms of improved services, quality and cost savings.

Question 72: Primary Care Initiative:
a. Pg 8 of RFP states that Executive Order No. 5 codified into law in June 2022 aimed 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. Can the state provide what percentage was achieved in 2023, 2024, and 2025 YTD?

b. Pgs 8 and 9 of RFP list participating provider groups: Does the respondent need to maintain

that list, or is there flexibility on which provider groups participate, or the criteria/conditions for provider participation?

Response:
a. SOCT health plan increased primary care spending to 7.35% in 2023, which was year one of the PCI, exceeding the state spending target of 6.9%. OSC is currently evaluating program year 2024 and YTD 2025.
b. The primary care initiative should be open to all qualifying provider groups who agree to the terms of the program.

Question 73*:* Member NPS and Client Satisfaction Scores: Can the state provide current results?

Response: Member NPS based on survey conducted by Advocacy vendor is 74

Question 74*:* In addition to CPT and DRG, is it possible to add a unique member ID to each claim so we can identify cost targets etc.

Response: Yes, this detail is available in the claims.

Question 75: Pharmacy: It would be helpful to receive high level pharmacy data: top drugs, avg. scripts per member, trend rates, utilization by brand, generic and specialty for the full population

Response: Please see recently posted high level utilization reports.

Question 76: Are physician administered drugs carved out of the medical plan?

Response: Physician administered drugs are covered under the medical plan.

Question 77*:* If PCI and alternative payment contracts are awarded to an organization other than the core medical plan carrier, is there an opportunity for the PCI/risk contracts vendor to specify data requirements and obligations for provision of continuous data file for the core medical carrier?

Response: The SOCT health plan and PCI use standard file formats but continue to evolve to include additional clinical data, such as Connie statewide HIE lab results, ADT, and CCDA, to further improve the PCI's ability to measure quality and outcomes. The PCI administrator may have an opportunity to specify data requirements.

Question 78: 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.
Are EOB updates notification to the member?

Response: No, the State would require a confirmation of the determination letter to the member.

Question 79: 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.
Are employees allowed to enroll both as an employee and dependent?

Response: No this is not allowed. No individual is permitted to maintain dual coverage as a covered Member or covered person under the Medical Benefit Plan, the Non-Medicare-Eligible Retiree Benefit Plan, a Partnership Plan, or the Medicare Advantage Plan. It is also prohibited for the same individual to be simultaneously enrolled as a Dependent or beneficiary of more than one State of Connecticut retiree or as the Dependent or beneficiary of a Member of the Medical Benefit Plan, Non-Medicare-Eligible Retiree Benefit Plan, a Partnership Plan, or the Medicare Advantage Plan.

Question 80: PCI Program
Will PCI guarantees (e.g., trend, quality) be evaluated separately or is that enterprise-wide?

Response: PCI guarantees will be evaluated separately.

Question 81: PCI Program
What's the process if we need to escalate or appeal a guarantee due to factors outside our control (e.g., late data from partners)?

Response: An escalation process will be determined with the chosen vendor.

Question 82: PCI Program
If provider data gaps impact performance, will OSC help enforce expectations or provide support in holding providers accountable?

Response: Yes

Question 83: PCI Program
What is the definition of “real-time” in the context of quality and financial reporting deliverables (e.g., daily, weekly, monthly refresh)?

Response: This is loosely defined as minimal lag between claim payment and its inclusion in quality/financial reporting: 2-week lag is reasonable; 6 months is not.

Question 84: PCI Program
Is the July 1, 2026 go-live with fully automated reporting a hard deadline, or is there flexibility for extensions based on complexity?

Response: Yes July 1, 2026 is a hard deadline.

Question 85: PCI Program
Can our staffing and implementation timelines be adjusted depending on final enrollment or data readiness?

Response: No

Question 86: PCI Program
Would a phased rollout (e.g., EMR integration, reporting tools) be acceptable as long as milestones are met?

Response: July 1, 2026 is the go-live date for full program implementation.

Question 87: 4 Proposal Requirements - 24. Standard Contract and Conditions—The Contractor must accept the State's contract language and conditions. See Standard Contract and Conditions - Attachment B.

Would you like any deviations from the State's contract to be noted in the Bid Exceptions & Deviations Form (Attachment A)?

Response: Yes, we would like your deviations noted in the bid exceptions and deviations form. The State will negotiate the terms of the Agreement with the selected bidder(s) once the contract is awarded.

Question 88: 4.3 Additional Procurement Requirements: - Additional required forms as described below must be submitted through CTSource by the deadline for submission of proposals. Does this provision include Attachments A through D and the Performance Guarantees exhibit? If not, could you please specify which forms are being referenced?

Response: This provision does not apply to Attachments A through D or the Performance Guarantee exhibit, additional procurement forms if necessary, are described in CTSource.

Question 89: 2.2. Objectives > 3. Primary Care Initiative (PCI) Administration

Does the state of CT already have the capability to aggregate and analyze HIE patient/clinical data on a longitudinal basis for population health or would this be a net new program/addition?

Response: SOCT PCI has begun to ingest lab results data from the Connie statewide HIE, as well as supplemental data files from SOCT PCI participating provider groups. The SOCT will begin to receive ADT and CCDA feeds from Connie. This will be a new build.

Question 90: 2.2. Objectives > 3. Primary Care Initiative (PCI) Administration

Please confirm: In this context, pre-certification refers to a provider proactively obtaining approval for a patient's treatment/procedure. Is this correct? If not, please define.

Response: Correct

Question 91: 2.4. Evaluation of Proposals > 5. PCI Program Administration.
Does the vendor who supports PCI need to integrate any native clinical criteria from existing programs into the scope of their solution?

Response: n/a

Question 92: Is CT open to third party risk adjustment/quality outcomes methodologies that are different fr m/supplemental to those currently implemented (e.g., providers of distinction)? If not open to this option - can you provide details on which parts of the program will persist after award?

Response: The State is open to reviewing other transparent third-party risk adjustment and quality outcome methodologies.

Question 93: Does the state require/expect the vendor to source external data (not sourced only from the state's data) for medical or drug pricing data to support its intent identify cost savings opportunities?

Response: The State will review all proposed methods of cost savings opportunities.

Question 94: If Utilization Management is moved to the Medical Claims Administration section, what other Member Advocacy services (if any) will also be moved to the Medical Claims Administration section

Response: UM may be proposed as part of either the Medical Claims Administration or Member Advocacy and will be evaluated based on each proposal. There is no specific requirement to move other advocacy services if UM is awarded under the medical claims administration.

Question 95: Regarding Quality guarantee: Will all 7 "Core Measures" and 16 "Menu Measures" on the Aligned Measure Set be part of this risk?

Response: Yes, but there may be adjustments based on ability to calculate each measure. The final list would be agreed upon prior to the start of each measurement year and may be changed and updated to reflect changes that the OHS quality council approves.

Question 96: If Utilization Management is moved to the Medical Claims Administration section, will the State still adversely score Member Advocacy-only proposals without a UM solution

Response: No, UM will be scored as an independent scope regardless of whether it is bid in combination with advocacy services or medical claim admin services.

Question 97: Regarding Trend guarantee: Can you confirm that 0% of fees will be at risk if the 5% trend is maintained?

Response: For year 1 and 2 of the contract, if the vendor achieved a 5% trend, there will be no payment due to the State. In year 3 of the contract, the payment to the State begins at trend greater than or equal to 5.0% trend.

Question 98: Is the State open to receiving information on programs currently administered by point solution vendors?

Response: Yes.

Question 99: Regarding Quality guarantee: How are vendors scored if not every measure on the Aligned Measure Set is achieved? For example, if the vendor meets 15 measures, exceeds 6 measures, and misses 2 measures

Response: The quality guarantee does not require meeting the benchmark or year-over-year improvement on every measure. Please review the performance guarantee spreadsheet that defines the dollars at risk or bonus payments paid based on the percentage of measures for which the benchmark or year-over-year improvement is met.

Question 100: Can the State make claims data available for analysis to help inform our ability to impact trends? (There was an email dated August 1, 2025, that says two data files were made available via SFTP to vendors with an NDA on file. Can you provide a link to the SFTP site?)

Response: Data files have been released to bidders with an NDA on file. If you still do not have the data please contact Emily Peters and Terry DeMattie through Proposal Tech.

Question 101: Does the State anticipate putting the point solutions out to RFP in the future? If yes, can you provide approximate dates?

Response: The State may decide to put the point solutions out to RFP in the future, but no timeframe has been determined.

Question 102: In section 2.4 Evaluation of Proposals, you reference that Finalists will be selected based on overall scores and or scores in categories related to specific services. Can you share the specific scoring rubric that will be used by the committee to score the RFP including weighting by category and how vendors will be ranked?

Response: Rubric has been posted

Question 103: Can also share the composition of the committee that will evaluate the RFP and determine finalists and award?

Response: The RFP Committee is made of up of SEBAC labor representatives, OPM representatives, and OSC employees. Segal is assisting as the subject matter experts.

Question 104: During the initial contracting with the State, our organization and the State created a navigation services agreement that was a blend of the State and our organization contracts. Can we provide that as part of our submission?

Response: Yes.

Question 105: Who is currently managing the Primary Care Initiative today?

Response: The PCI is currently being managed by Anthem in coordination with employees from the Office of the State Comptroller.

Question 106: Ideally, how do you envision the Member Advocacy, Navigation and Clinical Care Coordination vendors to support this PCI initiative (e.g., integration points, data exchange, collaboration)?

Response: Confirmed that all of the above are expected. It is expected that the Advocacy/navigation vendor will coordinate on clinical care programing and outreach (e.g. who calls the member post discharge), share data and information on discharge plans and other care management information, exchange data on high performing vendors, create pathways for PCI groups to refer to Advocacy and navigation services, and share pre-certification data if applicable.

Question 107: Many of the performance guarantee requests are more designed for the carrier/TPA. Can navigation participants submit alternatives that better reflect the program we will provide the State?

Response: Yes.

Question 108: For the Account Management Response Time performance guarantee, it's stated that response is required within 24 hours of the request. Please confirm this means one business day.

Response: Confirmed.

Question 109: Trend performance guarantee: To confirm, the trend guarantee is on medical claim dollars only. Pharmacy claims are not included?

Response: Medical pharmacy is included in the total cost of care guarantee, however, stand-alone pharmacy costs are not included.

Question 110: Trend performance guarantee: It appears the denominator of the calculation will have 12 months of runout and the numerator will have 6 months of runout. Is this correct?

Response: Each year of the trend guarantee will be based on claims incurred during the twelve months of the plan year (July through June) and paid during the plan year plus 6 months of runout through December compared to the prior year's claims incurred during the plan year and paid during the plan year with 6 months of runout through December.

Question 111: Quality performance guarantees: There are 23 measures within the Quality Council Aligned Measure Set. From the PG measurement, is the intent to aggregate the measures based on eligible members in each measure?

Response: Yes

Question 112: Service performance guarantee: 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. To clarify, you will be performing your own NPS survey for this PG? We perform our own, traditionally.

Response: Yes, the State will perform an independent survey.

Question 113: The bidders called and discussed the MEHIP. Will you be pulling this RFP entirely? If no, are you looking for financial quotes from those bidders responding to the medical claims administration portion of the bid? Are the current arrangements separate fully insured quotes or is this a self-insured offering for these entities?

Response: MEHIP administration will not be part of this RFP, however, the claims administration vendor must be willing and able to provide fully insured small group rating and claims administration for new and existing groups.

Question 114: For plan administration TPA services-related items, could you expand on your expectations for the guarantees given that some potential claims savings projections are tied directly to the performance of advocacy vendor, especially related to their performance on administering UM/CM programs.

Response: It is fully understood that each of the guarantees – financial, quality and customer satisfaction are impacted by the combined performance of the services being bid across all of the service lines being bid in this procurement. If the award is to multiple vendors, each will be held to the same guarantees ensuring that each has a stake in the overall performance of the plan as a whole and will be motivated to leverage their own resources and assist vendor partners in performing well on activities that will impact each measure.

Question 115: For Performance Guarantees it looks as if there are buckets (Claims Trend 50 percent, Service, 10 percent and Quality 10 percent) with no specific metric categories or

breakouts for each bucket. Please confirm that a bidder is able to provide their standard breakout as it relates to the different metrics that feed into each bucket?

Response: Not confirmed. The State, not the bidders, is setting the terms of the performance guarantees associated with this procurement.

Question 116: Please confirm that you would consider an alternative, non-bargained design that requires UM/CM to remain with the medical carrier.

Response: Confirmed, the State will review innovation plan options, the committee, which includes labor and management members will determine which innovation plan designs may be attractive and acceptable based upon the bidders proposals.

Question 117: On the attachment "State of CT - July 1, 2026, RFP Attachment File", for the tab "5 Self-Funded Claim Pick", We have no known historical trend available for most recent past years. Regarding future trend rate for '27, '28, and '29 do you have any guidance on what we should be applying specifically?

Response: This exhibit is requesting your projected PEPM claim cost and annual trend assumption for each year of the contract based on the data provided.

Question 118: During pre-RFP discussions, custom contracting and custom tiered arrangements were discussed, will the State consider forward looking discount and repricing analyses that will illustrate savings through potential custom contracting and tiering?

Response: Yes, but please provide as much justification and evidence of your pricing analysis as possible, any such repricing analysis should be in addition to, not a replacement of the traditional repricing requested.

Question 119: Repricing - It looks as if historical repricing is requested. There are 14 separate repricing files though so, we will be unable to provide the top providers. Should we be aggregating these amounts into a single analysis of top providers across all, or analyzing each distinctly?

Response: The directions for the repricing request are included in question 12.6.1.1 of the RFP. There were two repricing files provided, one for the State experience and one for the Partnership experience. A summary of the repricing exercise must be completed using the format provided on the "6.1 Claims Repricing" tab in State of CT - July 1, 2026 RFP Attachment File.xlsx.

Question 120: On the Disruption file we received, there are 61 TIN #'s listed as "999999999" and 15,242 PO Boxes listed for the addresses. The missing data will likely impact the results - are respondents allowed to exclude these from analysis or can you please provide guidance and/or update to data on how to handle or remove these items?

Response: If you are unable to match a provider based on the data fields provided in the disruption file (TIN/NPI/Name/Address), please note it in the response column in the State of CT - July 1, 2026 RFP Network Disruption File.xlsx. No providers from the files should be removed by a bidder.

Question 121: The 14 Repricing files combined are missing 14,645 TIN #'s, 61 POS codes, 13,270,493 procedure codes, 691 zip codes are listed as “99999” and 135,783 PO boxes are listed for the addresses. The missing data will likely impact the results and may be excluded from analysis if unable to match, please advise on how these should be handled, or can you provide updated files that remove these items from analysis?

Response: Updated repricing files have been provided with missing procedure codes. If you are unable to reprice a claim based on the provider data fields included in the file, the claim dollars associated with these claims should be captured in the “CLAIMS NOT ABLE TO BE REPRICED” section of the repricing response on the “6.1 Claims Repricing” tab in State of CT - July 1, 2026 RFP Attachment File.xlsx.

Question 122: Will individual tabs of the RFP be scored and considered in addition to an overall score?

Response: Yes.

Question 123: For responses with multiple partners, is there a formal requirement to disclose a combined partnership response (identifying all partners) prior to submission?

Response: There is no requirement to disclose partnerships or subcontractors prior to submission but if selected for an interview, the topic will likely be discussed.

Question 124: The RFP mentions a single sign on with a third party provider look up tool. Is this required if the responding vendor has an embedded provider lookup tool within its digital platform

Response: The State currently utilizes a provider look up tool from a third party and is open to alternatives.

Question 125: Which conditions does the State of CT have bundled payment programs for in current state?

Response: The State does not have any bundled payment programs today but would be interested in reviewing any bundle programs that bidders may offer.

Question 126: Beyond solutions like Flyte, Upswing, and Hinge, is the State of CT considering other condition areas to target with condition specific point solutions?

Response: The State will not disclose that information at this time.

Question 127: What are the State's expectations around 24/7 access to support and self-service? Are there concerns with current response times or escalation paths?

Response: The State prefers 24/7 access for member support and self-service.

Question 128: What are the State's expectations for vendor reporting in terms of tracking member engagement, referrals, enrollment into benefit programs, and demonstrating impact on outcomes and ROI?

Response: The State expects meaningful reporting that provides insight into how the advocacy/member services vendor impacts the utilization of services to ensure the right level of care at the most cost-effective place of service and overall member experience in appropriate issue resolution.

Question 129: In what ways does the State envision the selected partner will support not only high-cost claimants but also implement strategies to engage low- and medium-risk members to prevent future high-cost events?

Response: The State is interested in reviewing all strategies to manage low and medium risk levels to prevent future high-cost events.

Question 130: Will the State require performance guarantees that extend beyond the initial contract period into future renewals?

Response: The initial contract term is 3 years. Performance guarantees beyond the initial 3-year period would be a part of renewal negotiations, if the State and vendor cannot come to renewal terms the contract would be rebid.

Question 131: How does the State see AI and digital tools working in concert with human-based advocacy and navigation services to enhance the member experience, and what capabilities or approaches would be most important in achieving that balance?

Response: This is an area which is rapidly changing at the state level. The State will review proposals to determine the best options for its members. The State will follow guidance enacted by the Connecticut General Assembly or issued by the CT Department of Administrative Services with respect to AI and related digital tools.

Question 132: How does the State envision integrating services such as virtual care, second opinion, and advocacy into a unified member experience, and what role would you see the vendor playing in bringing those elements together?

Response: The State will review all proposals to improve member experience and clinical care.

Question 133: What capabilities is the State looking for in provider search tools — for example, combining quality insights, cost transparency, and AI-enhanced personalization beyond a standard provider directory?

Response: Key expected elements of a search tool include: provider tiering information, copay/out of pocket costs estimates, provider of distinction designations, site of service designations, the ability to surface relevant programs, clear and informative quality information, accurate provider demographics, including REL data if available. The State will review AI personal assistant capabilities but its not a requirement at this time.

Question 134: How will the State evaluate a vendor's business continuity capabilities, such as geographic distribution of operations and the ability to maintain service during local disruptions as part of its selection process?

Response: The State would expect a comprehensive plan to operate during all disruptions that reflect commonly accepted business practices.

Question 135: As you think about your longer-term strategy, what kinds of additional programs or care solutions most likely to add over time, for example, a surgical centers of excellence program or other high-value specialty care. And how important is it for those to be integrated without new procurement or contracting cycles?

Response: As noted in this RFP the State would like to see additional value-based arrangements for specialty care, the State may also consider extending the reach and scope of its provider of distinction program, other programmatic changes could be enacted through collective bargaining and any vendor would be expected to be flexible enough to assist in implementing new programs, plan designs or other initiatives that may be required through the contract term.

Question 136: How does the State define high-cost claimants (what is the threshold), and what percentage of the claimants fall into that category?

Response: For the purpose of managing medical high-cost claimants as requested in this RFP, $100k should be the threshold. See distribution below:

State of CT/Partnership

Medical Claimant Distribution

Time Period: Incurred April 2024 - March 2025; paid June 2025

Paid Range	Claimants	% of Total	Plan Paid
< $100K	215,507	98.8%	$1,386,318,169
$100k - $199k	1,651	0.8%	$227,575,162
$200k - $299k	499	0.2%	$120,906,365
$300k - $399k	211	0.1%	$72,598,847
$400k - $499k	96	0.0%	$42,871,626
$500k - $599k	61	0.0%	$33,046,523
$600k - $699k	28	0.0%	$18,087,031
$700k - $799k	18	0.0%	$13,554,838
$800k - $899k	3	0.0%	$2,458,105
$900k - $999k	8	0.0%	$7,530,496
$1M+	30	0.0%	$43,568,260
Total	**218,112**		**$1,968,515,422**

Question 137: What is the primary driver of this RFP? Are there specific pain points or unmet needs from the current vendor that the State is looking to address? Is there interest in AI-driven personalization?

Response: The State is required to send contracts out to bid every five (5) years. The priorities of the RFP are identified in the RFP description and evaluation criteria.

Question 138: How does the State envision behavioral health being delivered, and to what extent should it be integrated with primary care and navigation services?

Response: The State currently has a broad behavioral health network administered by the medical carrier. In addition, some PCI groups have integrated behavioral health into their services. Finally, the State recently contracted with Lyra Health (November 1, 2025 launch) to fill in gaps and ensure quick access to high quality behavioral health providers. The State expects each entity in this ecosystem to work together and create standard referral processes across entities. For example, referral processes for inpatient services from Lyra or PCI to the medical carrier, referrals from PCI to Lyra, or PCI or Lyra to the medical carrier for case management.

Question 139: How does the State view the value of vendors that can bring together multiple, third-party, integrated service, such as virtual care, second opinion, and advocacy, under a single contract to streamline procurement, security, and compliance?

Response: No response

Question 140: What is the State's vision for virtual care delivery, and how important is it for members to have the option of a longitudinal relationship with a dedicated virtual PCP?

Response: The State is interested in reviewing proposals, some of which may include virtual care.

Question 141: What are the State's key cost drivers today, and how are they being addressed by the current vendor?

Response: Key drivers are high-cost claimants, Ortho, behavioral health, ER costs, physician administered drugs and retail drugs.

Question 142: Which carriers or TPAs are being evaluated, and how important is it that the advocacy vendor integrates with them seamlessly?

Response: All vendors who submit bids will be evaluated. Seamless integration across vendor partners is expected.

Question 143: Does the State have an opinion on where the pre-certification process is done - carrier or advocacy partner?

Response: The State does not have a preference and will evaluate through the RFP process.

Question 144: How does the State define an ideal Centers of Excellence model, and what role should elements such as clinical navigation, care management, and direct access to high-performing providers across specialties play in that model?

Response: The State will evaluate all proposals some of which may include a center of excellence proposal.

Question 145: How does the State envision integrating a vendor's solution within its broader ecosystem? Through closed-loop integration, point solution access, or another approach?

Response: The State would be interested in leveraging vendor's solutions and will review all integration methods proposed.

Question 146: What level of transparency and timeliness does the State expect in reporting, and how important is real-time, self-service access?

Response: The State expects full transparency and places a high value on real-time self-service access.