

PROPOSALS MUST BE SEALED AND ADDRESSED TO:
AGENCY ADDRESS:

**REQUEST FOR PROPOSAL
THIS IS NOT AN ORDER**

PROPOSER (Name and Address)

Remove from Proposer list for this commodity/service. (Return this page only.)

Proposal envelope must be sealed and plainly marked in lower corner with due date and Request for Proposal # **1684 DHCAA-SM** Late Proposals will be rejected. Proposals MUST be date and time stamped by the soliciting purchasing office on or before the date and time that the Proposal is due. Proposals dated and time stamped in another office will be rejected. Receipt of a Proposal by the mail system does not constitute receipt of a Proposal by the purchasing office. Any Proposal which is inadvertently opened as a result of not being properly and clearly marked is subject to rejection. Proposals must be submitted separately, i.e., not included with sample packages or other Proposals. Proposal openings are public unless otherwise specified. Records will be available for public inspection after issuance of the notice of intent to award or the award of the contract. Proposer should contact person named below for an appointment to view the Proposal record. Proposals shall be firm for acceptance for sixty (60) days from date of Proposal opening, unless otherwise noted. The attached terms and conditions apply to any subsequent award.

Proposals MUST be in this office no later than January 13, 2010 (2:00 PM CST)	Public Opening <input type="checkbox"/> No Public Opening <input checked="" type="checkbox"/>
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Name (Contact for further information)
Susan McKercher

Phone 608.267.7637	Date October 30, 2009
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Quote Price and Delivery FOB

Description

**Southeast Wisconsin
Medicaid Managed Care Organizations**

The Wisconsin Department of Health Services seeks to procure BadgerCare Plus managed care contracts in Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha counties. Services are to begin on August 1, 2010. Organizations awarded contracts by the State will be required to provide and manage the health care services for members enrolled in BadgerCare Plus Standard and Benchmark plans in these counties – approximately 240,000 members. The delivery structure of the Respondents must be that of a managed care organization with an OCI license in Wisconsin. The objective of the RFP is to improve quality of care for BadgerCare Plus members as well as decrease health care costs.

Payment Terms:	Delivery Time:
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We claim minority bidder preference [Wis. Stats. s. 16.75(3m)]. Under Wisconsin Statutes, a 5% preference may be granted to CERTIFIED Minority Business Enterprises. Bidder must be certified by the Wisconsin Department of Commerce. If you have questions concerning the certification process, contact the Wisconsin Department of Commerce, 5th Floor, 201 W. Washington Ave., Madison, Wisconsin 53702, (608) 267-9550.

We are a work center certified under Wis. Stats. s. 16.752 employing persons with severe disabilities. Questions concerning the certification process should be addressed to the Work Center Program, State Bureau of Procurement, 6th Floor, 101 E. Wilson St., Madison, Wisconsin 53702, (608) 266-2605.

Wis. Stats. s. 16.754 directs the state to purchase materials which are manufactured to the greatest extent in the United States when all other factors are substantially equal. Materials covered in our proposal were manufactured in whole or in substantial part within the United States, or the majority of the component parts thereof were manufactured in whole or in substantial part in the United States.

Yes No Unknown

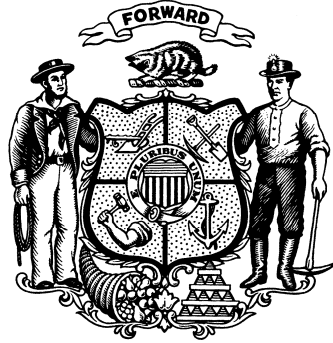
In signing this Proposal we also certify that we have not, either directly or indirectly, entered into any agreement or participated in any collusion or otherwise taken any action in restraint of free competition; that no attempt has been made to induce any other person or firm to submit or not to submit a Proposal; that this Proposal has been independently arrived at without collusion with any other Proposer, competitor or potential competitor; that this Proposal has not been knowingly disclosed prior to the opening of Proposals to any other Proposer or competitor; that the above statement is accurate under penalty of perjury.

We will comply with all terms, conditions and specifications required by the state in this Request for Proposal and all terms of our Proposal.

Name of Authorized Company Representative (Type or Print)	Title	Phone ()	
		Fax ()	
Signature of Above	Date	Federal Employer Identification No.	Social Security No. if Sole Proprietor (Voluntary)

REQUEST FOR PROPOSAL

**STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
DIVISION OF HEALTH CARE ACCESS AND ACCOUNTABILITY**



RFP # 1684 DHCAA-SM

Southeast Wisconsin Medicaid Managed Care Organizations

PROPOSALS MUST BE RECEIVED BY

2:00 PM CST on Wednesday, January 13, 2010

**LATE PROPOSALS WILL BE REJECTED
FAXED PROPOSALS WILL NOT BE ACCEPTED
THE STATE RESERVES THE RIGHT TO REJECT ANY AND ALL PROPOSALS**

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SECTION 1: GENERAL INFORMATION

1.1 Introduction

The Wisconsin Department of Health Services (DHS), Division of Health Care Access and Accountability (DHCAA) is requesting Proposals from qualified managed care organizations (MCOs) seeking to establish a risk-based, capitated contract with DHS for providing and managing the health care services for members enrolled in BadgerCare Plus Standard and Benchmark plans in Milwaukee, Washington, Ozaukee, Waukesha, Racine and Kenosha counties. Proposers are required to provide services to members in all six counties. The services required as part of the contract, which are fully described in the BadgerCare Plus Contract posted herewith as Appendix A, include providing covered physical health, behavioral health, and dental services; establishing and managing a provider network; credentialing and contracting with providers; utilization management, disease management, quality management, customer service, financial management, claims management, maintaining sufficient information systems; and promoting coordination and continuity of preventive health services and other medical care.

For purposes of services and specifications prescribed in this Request for Proposal (RFP), MCOs will be referred to as **HMOs** from this point forward in this and subsidiary documents posted as part of this RFP.

Through this RFP, the State seeks to contract with at least three (3) HMOs that deliver the highest quality of health care services to BadgerCare Plus members at the most favorable, competitive prices. Specifically, the goals of the RFP are to:

- Measurably improve healthcare outcomes for BadgerCare Plus members in the following areas:
 - Childhood Immunizations
 - Blood Lead Screening for one and two year olds
 - Tobacco Cessation
 - Asthma Management
 - Diabetes Management
 - Healthy Birth Outcomes
- Improve care coordination, especially for high cost individuals with chronic illness.
- Reduce inappropriate uses of services such as unnecessary ER visits.
- Increase dental utilization.
- Lower the overall cost of healthcare.
- Simplify and strengthen the healthcare marketplace.

This document provides interested parties with information to enable them to prepare and submit a Proposal for this contract under these and further described premises.

1.2 Procuring and Contracting Agency

This RFP is issued by the Wisconsin Department of Health Services which is the sole point of contact for the State of Wisconsin during the selection process. The person responsible for managing the procurement process is Susan McKercher.

The contacts resulting from this RFP will be administered by the Wisconsin Department of Health Services, Division of Health Care Access and Accountability, Bureau of Benefits Management (BBM). The contract administrator will be the Director of the Bureau of Benefits Management or designee. The BBM Director (“Director”) shall represent all of the Department’s interests and rights under the contracts.

1.3 Clarification and/or Revisions to the Specifications and Requirements

Any questions concerning this RFP must be submitted to Susan McKercher (with a copy to Timothy Holthaus). Pre-Vendor Conference questions must be submitted on or before close of business November 6, 2009. Post-Vendor Conference questions must be submitted on or before close of business November 20, 2009. All questions are to be submitted via email as follows:

Susan McKercher, Purchasing Manager
Susan.McKercher@dhs.wisconsin.gov
email cc to: Timothy.Holthaus@dhs.wisconsin.gov

Telephone questions are not allowed. Any oral responses, information, dates, and/or advice received by a prospective Proposer from the Department or Department staff shall not, in any manner whatsoever and whether before or after the release of this RFP, be binding on the State of Wisconsin, unless followed-up and explicitly confirmed and stated in writing by the State.

Vendors are expected to raise any questions, exceptions, or additions they have concerning the RFP DOCUMENT at these points in the RFP process. If a vendor discovers any significant ambiguity, error, conflict, discrepancy, omission, or other deficiency in this RFP, the vendor should notify immediately the above named individual of such error and request modification or clarification of the RFP.

In the event that it becomes necessary to provide additional clarifying data or information, or to revise any part of this RFP, revisions/amendments and/or supplements will be provided to all enrollees of this initial RFP via posting to the Wisconsin Vendornet System website under RFP 1684 DHCAA-SM.

Any contact with State employees concerning this RFP is prohibited, except as authorized by the RFP manager during the period from date of release of the RFP until the notice of intent to contract is released.

1.4 Vendor Conference

A Vendor Conference will be held on November 11, 2009 at 9:00 AM CST at the Country Springs Hotel, 2810 Golf Road, Pewaukee, WI 53072 to respond to questions and to provide any needed additional instruction to vendors on the submission of Proposals. All vendors who intend to respond to the RFP must attend this Conference. Proposals from vendors who will not have attended this conference will not be accepted for consideration and will be rejected upon receipt.

For further information and registration, see the following:

<http://dhs.wisconsin.gov/Medicaid/ratereform/managedcare/RFP1684DHCAA-JS%20SE%20WI%20MCOVendorConferenceAnnouncement.pdf>

1.5 Letter of Intent to Propose

Vendors intending to submit a Proposal under the auspices of this RFP must notify the Department of such intent via email no later than close of business on November 18, 2009. Such notice must be submitted via the email protocol described in Section 1.3.

1.6 Reasonable Accommodations

The Department will provide reasonable accommodations, including the provision of informational material in an alternative format, for qualified individuals with disabilities upon request. If you think you need accommodations contact Susan McKercher at (608) 267-7637 or Susan.McKercher@dhs.wisconsin.gov by November 6, 2009.

1.7 Calendar of Events

Listed below are specific and estimated dates and times of actions related to this RFP. The actions with specific dates must be completed as indicated unless otherwise changed by the State. In the event that the State finds it necessary to change any of the specific dates and times in the calendar of events listed below, it will do so by issuing a supplement to this RFP. There may or may not be a formal notification issued for changes in the estimated dates and times.

DATE	EVENT
October 30, 2009	Date of issue of the RFP (posted to VendorNet)
November 6, 2009	Deadline for Vendor Pre-Conference Questions
November 11, 2009 – 9:00 a.m. CST	Vendor conference (attendance required)
November 18, 2009	Deadline for Letter of Intent to Propose
November 20, 2009	Deadline for Vendor Post-Conference Written Questions
December 4, 2009 (estimated)	All Questions and Answers posted to VendorNet
December 14, 2009	Deadline for submitting provider network test files

January 13, 2010 – 2:00 p.m. CST	Proposals due from vendors
Week of February 8, 2010 (estimated)	Interviews of invited vendors
March 12, 2010 (estimated)	Notification of intent to award sent to vendors/ HMO certification begins
May 15, 2010 (estimated)	Completion of HMO certification
June 1, 2010 (estimated)	Contract effective date
August 1, 2010 (estimated)	Member enrollment phase-in begins: HMOs begin providing services to first group of members
September 1, 2010 (estimated)	Member enrollment phase-in continues: HMOs begin providing services to second group of members
October 1, 2010 (estimated)	Member enrollment phase-in ends: HMOs begin providing services to third group of members

Vendors who are awarded the RFP must complete DHS’s HMO certification process to the satisfaction of the Department as a condition of the State issuing a contract to the Vendor. Vendors will have approximately two months to complete this process. More information on the HMO certification requirements can be found in Appendix C. After signing the contract with the State, Vendors will have approximately two months prior to members being enrolled in their HMO.

1.8 Contract Term and Funding

The contract shall be effective on the date indicated in the contract and shall run for three years and six months from that date, with an option by mutual agreement of the agency and contractor, to renew for two additional one-year periods.

DHS will provide an HMO with a monthly capitated payment for each person who enrolls. Capitation rates are determined using an actuarially sound methodology for projecting the average per person cost of services for persons entitled to the BadgerCare Plus benefit. The capitated amount will be a combination of a rate set by the Department representing the medical costs of the benefit and a cost submitted by the Proposer (via Appendix B) representing the non-medical costs of administering the benefit. For BadgerCare Plus capitation rates in the current and past years and information on the methodology used to develop these rates see Section 8 and Appendices E-1 and E-2.

1.9 VendorNet Registration

The State of Wisconsin’s purchasing information and vendor notification service is available to all businesses and organizations that want to sell to the state. Anyone may access VendorNet on the Internet at <http://vendornet.state.wi.us> to get information on state purchasing practices and policies, goods and services that the state buys, and tips on selling to the state. Vendors may use the same Web site address for inclusion on the bidders list for goods and services that the organization wants to sell to the state. A subscription with notification guarantees the

organization will receive an e-mail message each time a state agency, including any campus of the University of Wisconsin System, posts a request for proposal or a request for Proposal in their designated commodity/service area(s) with an estimated value over \$25,000. Organizations without Internet access receive paper copies in the mail. Increasingly, state agencies also are using VendorNet to post simplified proposals valued at \$25,000 or less. Vendors also may receive e-mail notices of these simplified proposal opportunities.

SECTION 2: BACKGROUND ON WISCONSIN'S MEDICAID PROGRAM

The State of Wisconsin offers Wisconsin residents access to a variety of health care services through its ForwardHealth programs. These programs, which include Medicaid and BadgerCare Plus, strive to bring high-quality health care to members across the state. Information on all of the benefit programs offered by DHS can be found at: <http://dhs.wisconsin.gov/ForwardHealth/>. Information on the ForwardHealth programs relevant to this RFP is detailed below.

2.1 Legal Authority of Wisconsin's Medical Assistance Program

Title XIX of the Social Security Act authorizes the U.S. Department of Health and Human Services (DHHS) to financially assist states in providing health care services to people with limited resources. This program is commonly referred to as medical assistance (MA), Medicaid or Title 19. Wisconsin's MA program is authorized under Chapter 49 of the state statutes and is administered by the Division of Health Care Access and Accountability (DHCAA) in the Department of Health Services (DHS). DHCAA administers the program under state and federal law and in conformity with the MA plan submitted and approved by the federal Centers for Medicare and Medicaid Services (CMS), a division of DHHS.

2.2 Overview of Wisconsin's Health Benefits Programs

BadgerCare Plus, Wisconsin's MA program for families, was implemented on February 1, 2008. This program consolidated and streamlined enrollment in Medicaid for families by replacing the former AFDC-Medicaid, Healthy Start and BadgerCare programs. BadgerCare Plus offers access to health care to eligible children under 19 years of age, pregnant women, and families in Wisconsin. On January 1, 2009, BadgerCare Plus was expanded to also offer basic health care services to eligible, long-term uninsured adults.

BadgerCare Plus consists of three comprehensive benefit plans—BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, and the BadgerCare Plus Core Plan. The Standard Plan is for families with income at or below 200% of the Federal Poverty Level (FPL). The Benchmark Plan which provides more limited services than the Standard Plan, is for children and pregnant women with income above 200% of the FPL, and for certain self-employed parents and caretakers. The Core Plan is for adults with no dependent children and income at or below 200% FPL.

BadgerCare Plus also has some limited health benefit programs that include:

- Family Planning Waiver program;

- Prenatal Program; and
- Emergency Services for documented immigrants.

More information on all of the health benefit plans and programs offered under the BadgerCare Plus program can be found in the BadgerCare Plus Eligibility Handbook at: <http://www.emhandbooks.wi.gov/bcplus/> and the ForwardHealth online handbooks at:

<https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/taproposal/151/Default.aspx>

In addition to BadgerCare Plus, DHS provides health care benefits through its Medicaid SSI program to low-income individuals that are over age 65, blind, or disabled. The eligibility and benefit rules for these individuals, many of whom are automatically eligible through the Social Security Administration's Supplemental Security Income (SSI) program, can be found in the Medicaid Elderly, Blind, and Disabled Handbook located at:

<http://www.emhandbooks.wi.gov/meh-ebd/>

Current enrollment data for all DHS health benefit programs can be found at:

<https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Member/caseloads/enrollment/enrollment.htm.spage>

The contracts awarded to HMOs as an outcome of this RFP are for providing health care services to members enrolled in the BadgerCare Plus Standard Plan and BadgerCare Plus Benchmark Plan ONLY. HMOs will not be required to provide services to members enrolled in the BadgerCare Plus limited health benefit programs as part of this RFP. Members enrolled in the BadgerCare Plus Core Plan and Medicaid SSI Program in Milwaukee, Washington, Ozaukee, Waukesha, Racine and Kenosha counties will receive their health care services from HMOs that have a separate existing contract with DHS to provide Medicaid services to members in this region.

2.3 Eligibility for BadgerCare Plus Standard and Benchmark Plans

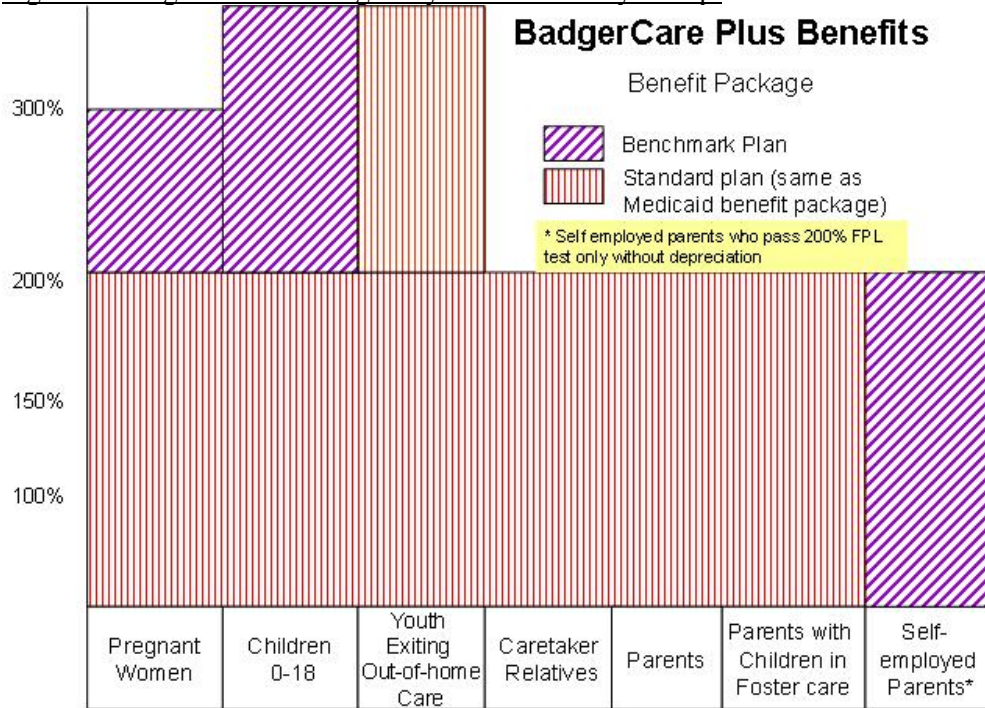
Enrollment in BadgerCare Plus Standard and Benchmark Plans is open to the following individuals:

- Children under 19 years of age;
- Pregnant women;
- Parents and caretakers of children under 19;
- Young adults leaving out-of-home care (such as foster care);
- Parents and caretaker relatives whose children have been removed from the home and placed in out-of-home care; and
- Self-employed parents and caretakers with income that does not exceed 200% FPL after deducting depreciation.

Whether a member enrolls in the Standard or Benchmark plan depends on that individual's income and eligibility group. In general, the Standard Plan is for families with income at or

below 200% of the FPL. The Benchmark Plan, which provides more limited services than the Standard Plan, is for families with income above 200% of the FPL, and for certain self-employed parents and caretakers. See Figure 1.

Figure 1: BadgerCare Plus Eligibility and Benefits by Group.



More information on eligibility requirements can be found in the BadgerCare Plus Eligibility Handbook at: <http://www.emhandbooks.wi.gov/bcplus/>

2.4 BadgerCare Plus Service Delivery

Health care services under BadgerCare Plus are provided either on a fee-for-service (FFS) basis or through a managed care arrangement. Under FFS, members obtain services through participating health care providers, who in turn submit claims to the BadgerCare Plus program for reimbursement of each covered service provided. Under a managed care arrangement, the State pays an HMO a monthly capitation payment for each BadgerCare Plus member enrolled with that HMO. In return for those monthly capitation payments, the HMO, through its provider network, provides comprehensive health services to its enrolled members. For information on how DHS determines capitation payments see Appendix E.

As of October 2009, DHS had contracts with 16 HMOs to provide services to BadgerCare Plus members throughout Wisconsin. In areas where there are at least two HMOs providing services - including the six counties covered by this RFP (Milwaukee, Washington, Ozaukee, Waukesha, Racine and Kenosha) - BadgerCare Plus members are required to enroll in an HMO. In most areas where there is only one HMO present, members have the option of receiving services through the HMO or under FFS, as required by federal law. Certain members may also qualify for an exemption from HMO enrollment if they meet certain criteria, such as a high-risk third

trimester pregnancy or continuity of care concerns. HMOs have the option of requesting a maximum member enrollment level. As of September 2009, there were 696, 901 members enrolled in BadgerCare Plus statewide. Of those, approximately 83%—578,101 members—were enrolled in HMOs.

2.5 Covered Services under BadgerCare Plus Standard and Benchmark Plans

BadgerCare Plus Standard and Benchmark Plans share many of the same policies and procedures. However, under the Benchmark Plan, coverage of health care services is more limited and cost-sharing by the member upon receipt of services may be greater. Specific information on covered services and required co-payment amounts under the Standard and Benchmark plans can be found in the BadgerCare Plus Eligibility Handbook at: <http://www.emhandbooks.wi.gov/bcplus/> and the ForwardHealth online handbooks at:

<https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/taproposal/151/Default.aspx>

In addition, HMOs may provide other services and treatment methods beyond these BadgerCare Plus covered services.

HMOs in the six counties covered by this RFP are required to provide dental services to BadgerCare Plus members. However, HMOs have the option of covering chiropractic services. BadgerCare Plus members enrolled in HMOs that do not cover chiropractic services are entitled to receive them from MA-certified providers on a FFS basis.

Effective February 1, 2008, pharmacy services and selected drug related supplies became reimbursed on a fee-for-service (FFS) basis and were “carved-out” of the capitation payments the state makes to HMOs for BadgerCare Plus members. As a result, BadgerCare Plus members enrolled in HMOs obtain their prescription drugs through an MA-certified pharmacist on a FFS basis and pharmacies submit claims directly to the State. DHS produces a pharmacy extract that contains each member’s pharmacy claim detail record, member ID, member name/DOB/gender, claim status, prescription number, drug name, diagnosis code, days supply, billed amount, pharmacy and prescribing provider ID. This extract is available electronically to the HMOs on a daily basis.

2.6 Enrollment into BadgerCare Plus

Individuals may apply for BadgerCare Plus through multiple avenues:

1. ACCESS website: access.wi.gov.
2. Telephone Interview by calling 1-800-362-3002.
3. Mail-in hardcopy application form: <http://dhs.wisconsin.gov/forms/F1/F10182.pdf>.
4. Face-to-Face Interview at the individual’s local county or tribal agency.

Upon enrollment in BadgerCare Plus, members residing in an HMO service area receive an HMO enrollment packet. The packet has an enrollment form, a list of available HMOs, instructions on how to choose an HMO and how to find out if a provider is affiliated with an HMO. BadgerCare Plus families must choose one HMO for all members of the family. If a member or family does not choose an HMO within two weeks and lives in an area covered by

two or more HMOs, the member or entire family is automatically assigned to an HMO. Once enrolled, the member or family has up to three months to change HMOs. After the initial three months, the member or family is locked into the HMO and cannot change for nine months. After nine months, the member or family may change the HMO assignment at any time. If the member or family chooses a different HMO, another lock-in period is required.

2.7 HMO Enrollment in the RFP Region

Upon award of contracts through this RFP, all BadgerCare Plus members currently enrolled in Milwaukee, Washington, Ozaukee, Waukesha, Racine and Kenosha counties will be notified of the HMOs providing services in the region and given an opportunity to select an HMO. Each member in these counties will receive an enrollment packet with the following information:

- A list of available HMOs;
- A one-page flyer for each available HMO (These flyers will be designed by the HMO and approved by DHS.);
- Instructions on how to choose an HMO; and
- Instructions on how to find out if a provider is affiliated with an HMO.

One of the ways in which members will be instructed to choose an HMO is through the ACCESS website: access.wi.gov. For those members without electronic capability, a customer service phone line will be available. For others, ACCESS will feature an HMO Enrollment Selection Tool that will use information on where the member lives, provider preference, the member's health conditions, and HMO quality scores from performance measurements to help a member choose which HMO is best for them. HMO quality scores will be based on the HMO's performance on select HEDIS, CAHPS, and other quality measures for the BadgerCare Plus population. Until these data are available, however, (approximately 18 months after the implementation of the contract) the HMO quality score will be replaced by a ranking order based on the score the HMO received in the review of its Technical Proposal.

Members who do not select an HMO through this initial process will be automatically assigned to an HMO. For BadgerCare Plus families, all members of a family will be automatically assigned to the same HMO. The percentage of members automatically assigned to any HMO will be determined based on the score the HMO receives on the Cost Proposal section of this RFP. Specifically, the HMO with the lowest Cost Proposal will receive 60% of auto-assignments and the second lowest Cost Proposal will receive 25% of auto-assignments. The remaining 15% of auto-assignments will be allocated evenly, at the State's discretion, among the third lowest Cost Proposal and any additional HMOs that may be awarded a contract through the RFP. If any HMO reaches its enrollment cap before the allotted auto-assignments have been allocated to that HMO, the remaining auto-assignments will be given to the HMO with the next lowest Cost Proposal.

The allocation of auto-assignments will remain intact until the Department has calculated the HMOs' performance on select quality measures—after approximately the first eighteen (18) months of the contract. After this time period, new members will be auto-assigned to HMOs based on the HMOs' quality performance.

Given the number of members enrolled in BadgerCare Plus in the RFP region, the Department plans to phase-in enrollment of members into the HMOs who were awarded contracts through the RFP over three months. The first group of members is expected to begin receiving services from HMOs beginning August 1, 2010; the second group will begin September 1, 2010; and the third group will begin October 1, 2010. The State reserves the right, at its sole discretion, to adjust this enrollment schedule based on changes in federal or state laws and/or the level of funding available to support these services.

2.8 HMO Scope of Work

The relationship between the state's MA program and participating HMOs is governed by federal and state regulations, and by contracts established between DHS and the HMOs. Proposers ultimately awarded contracts under this RFP process will be required to meet the requirements of the BadgerCare Plus Contract (Appendix A to this RFP). In addition, upon award of the contract, selected HMOs must complete certification requirements to the satisfaction of the Department as a condition of executing a contract with the State. A list of certification requirements can be found in Appendix C.

Historically, DHS has contracted with all HMOs that successfully complete the certification requirements which include, among other things, establishing an adequate provider network that meets DHS contract requirements. DHS' current contracts with HMOs not providing services to BadgerCare Plus members enrolled in Standard and Benchmark Plans in Southeast Wisconsin will continue to be secured through this process. Certification requirements for these contracts can be found at:

<https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/referenceAndTools.htm.spage>

DHS' fiscal agent, Electronic Data Systems, Inc. (EDS), provides administrative services that support the state's MA program and several related programs. These services include processing claims, distributing MA eligibility cards, reviewing prior authorization requests, managing pharmacy point-of-sale systems, collecting BadgerCare Plus premiums, coordinating benefits, and developing and supporting information systems. EDS also supports the state's web-based Medicaid Management Information System (MMIS), known as ForwardHealth interChange. Through ForwardHealth interChange, MA providers and DHS trading partners—including HMOs—can verify member enrollment, submit electronic claims, make claims adjustments, submit prior authorizations, and download the pharmacy extract. The HMOs' ForwardHealth interChange homepage can be found at:

<https://www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/taproposal/38/Default.aspx>

2.9 Additional Information

In preparing responses to this RFP, applicants are encouraged to review the following websites:

- Information on the BadgerCare Plus program found on the DHS website:
<http://dhs.wisconsin.gov/>
- Information on the ForwardHealth Managed Care References and Tools webpage, particularly the Quality Reports:
<https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/managed%20care%20organization/referenceAndTools.htm.spage>
- Demographic and enrollment data:
 - <https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Member/caseloads/enrollment/enrollment.htm.spage>
 - <https://www.forwardhealth.wi.gov/WIPortal/portals/0/staticContent/Member/caseloads/481-caseload.htm>
 - <http://dhs.wisconsin.gov/badgercareplus/enrollmentdata/enrolldata.htm>

A website with data and other information specific to this RFP will be made available by the Department after the release of the RFP. The URL for this website is as follows:

<http://dhs.wisconsin.gov/medicaid/ratereform/managedcare/index.htm>

SECTION 3: PREPARING AND SUBMITTING A PROPOSAL

3.1 General Instructions

The evaluation and selection of a contractor will be based on the information submitted in the vendor's Proposal plus references and any required on-site visits or oral interviews. Except as provided in Section 4, failure to respond to each of the requirements in the RFP will be the basis for rejecting a response.

Elaborate Proposals (e.g., expensive artwork), beyond that sufficient to present a complete and effective Proposal, are not necessary or desired.

3.2 Incurring Costs

The State of Wisconsin is not liable for any cost incurred by Proposers in replying to this RFP.

3.3 Submitting the Proposal

Proposers must submit Proposals in strict accordance with the requirements set forth in this section. All materials must be submitted to:

Susan McKercher
Purchasing Manager
Department of Health Services
Division of Enterprise Services
1 W. Wilson St., Room 750
Madison, WI 53701-7850
(608) 267-7637
FAX: 608.264.9874

Proposals must be received in the above office by the specified date and time stated below. All Proposals must be time-stamped as accepted by the Purchasing Office by the stated time. Proposals not so stamped will not be accepted. Receipt of a Proposal by the State mail system does not constitute receipt of a Proposal by the Purchasing Office, for purposes of this RFP.

Proposals must be prepared in two (2) components: Technical Proposal and Cost Proposal, prepared in accordance with the requirements stated in this RFP. The original and seven (7) paper copies of the Technical Proposal under sealed cover and the original and two (2) paper copies of the Cost Proposal sealed under separate cover must be received at the above address no later than **2:00 PM CST on Wednesday, January 13, 2010.**

In addition, both Technical and Cost Proposals must be submitted on a total of five (5) reproducible CDs or DVDs recorded as follows:

- one disc for the entire Technical Proposal including any proprietary information; enclose this disc within the Technical Proposal package.

- one disc for the Technical Proposal excluding the proprietary information reported on the Designation of Confidential and Proprietary Information form (DOA-3027). Enclose this disc within the Technical Proposal package. This disc would be used by the Department in responding to open records requests concerning this RFP.
- the two (2) distinct discs related to the **provider network** as described in the instructions in Appendix D. These two discs must be clearly labeled as prescribed in Appendix D. Enclose these discs within the Technical Proposal package.
- one disc for the Cost Proposal containing a PDF of the completed and signed Appendix B. Enclose this disc within the Cost Proposal package.

Proposers are cautioned that receipt of a Proposal package by the United States Postal Service, State of Wisconsin mail system or a commercial carrier does not constitute receipt of a Proposal by the Department for purposes of this procurement. All Proposals received after the closing date and time will not be reviewed and will be returned, unopened, to the Proposer. **No exceptions will be allowed.**

The outside cover of the package containing the **Technical Proposal** (paper and discs) must be marked:

TECHNICAL PROPOSAL
 Southeast Wisconsin Medicaid Managed Care Organizations RFP
Name and Address of Proposer
 Due: January 13, 2010, 2:00 PM CST
 RFP #1684 DHCAA-SM

The outside cover of the package containing the **Cost Proposal** (paper and discs) must be marked:

COST PROPOSAL
 Southeast Wisconsin Medicaid Managed Care Organizations RFP
Name and Address of Proposer
 Due: January 13, 2010, 2:00 PM CST
 RFP #1684 DHCAA-SM

3.4. Transmittal Letter

A Transmittal Letter must accompany the RFP package. It must be on official business letterhead of the prime Proposer submitting the proposal, and must be signed by an individual authorized to legally bind the Proposer.

The Transmittal Letter must stipulate the following:

- The Proposer is the prime contractor and is a corporation or other legal entity;
- A statement identifying any and all subcontractors that will be responsible for fulfilling the requirements of this RFP is included in the proposal as appropriate;
- No attempt has been made or will be made by the Proposer to induce any other person or firm to submit or not to submit a proposal;
- No cost or pricing information has been included in the Transmittal Letter or the Technical Proposal;
- The Technical and Cost Proposal are valid for a minimum of six months from the proposal due date;
- The person signing this proposal is authorized to make decisions on behalf of the Proposer's organization as to the prices quoted and that the person has not participated, and will not participate, in any action contrary to the this statement;
- Assurance that the Proposer will agree to execute and fulfill a contract according to the conditions and terms specified in this RFP;
- That the proposal is predicated upon the requirements, terms, and conditions of this RFP, all its attachments, and any supplements or revisions thereof; and
- That an individual authorized to legally bind the Proposer is signing this Transmittal Letter.

3.5 Proposal Organization and Format

Technical Proposals must be typed and submitted on 8.5 by 11 inch paper bound securely; presented in 12-point Times New Roman font; and appear in the order and by the number assigned in the RFP. Proposals must be organized with the following headings and subheadings. Each heading and subheading must be separated by tabs or otherwise clearly marked. Page limits for each section where appropriate are indicated in parentheses. Attachments and/or Appendices are not allowed. An outline prescribing the RFP sections which must be submitted or responded to in the Technical Proposal is illustrated below:

- I. Cover page (1 page)
- II. Introduction (2 pages)
- III. Response to Mandatory requirements (Section 5)
 - A. Maximum Enrollment Worksheet (Appendix F) (1 page)
- IV. Response to Technical Requirements (Section 6)
 - (not more than 200 pages arrayed as follows):
 - A. Medicaid Managed Care Experience (Section 6.1) (100 pages or less)
 - B. Quality Performance Strategy (Section 6.2) (75 pages or less)
 - C. Medical Home Strategy (Section 6.3) (25 pages or less)
- V. Response to Optional Requirements (Section 7):
 - Integrated Delivery System Requirements (not more than 10 pages)
- VI. Required forms
 - A. Designation of Confidential and Proprietary Information
 - B. Vendor Information
 - C. Vendor Reference

The Proposer must separately submit its **Cost Proposal** on the form provided in Appendix B according to the instructions provided. Failure to provide any requested information in the prescribed format may result in disqualification of the Proposal. No mention of the Cost Proposal or any of its details may be made in the Technical Proposal.

3.6 Multiple Proposals

Multiple Proposals from a vendor will not be permissible. Only one Proposal per OCI-licensed HMO will be accepted.

3.7 Oral Presentations and Site Visits

Top scoring Proposers (based on an evaluation of the written Proposals) may be required to participate in interviews and/or site visits to support and clarify their Proposals, if requested by the State. The State will make every reasonable attempt to schedule each presentation at a time and location that is agreeable to the Proposer. Failure of a Proposer to interview or permit a site visit on the date scheduled may result in rejection of the vendor's Proposal.

3.8 Withdrawal of Proposals

Proposals shall be irrevocable until contract award unless the Proposal is withdrawn. Proposers may withdraw a Proposal in writing at any time up to the Proposal closing date and time or upon expiration of five (5) business days after the due date and time if received by the RFP project manager. To accomplish this, the written request must be signed by an authorized representative of the Proposer and submitted to the RFP project manager. If a previously submitted Proposal is withdrawn before the Proposal due date and time, the Proposer may submit another Proposal at any time up to the Proposal closing date and time.

SECTION 4: PROPOSAL SELECTION AND AWARD PROCESS

4.1 Preliminary Evaluation

The Proposals will be reviewed initially to determine if the mandatory requirements listed in Section 5 of the RFP are met. Unless the best interests of the state demand otherwise, as solely determined by the Department in its discretion, failure to meet mandatory requirements will result in rejection of the Proposal. The Department does not anticipate the need to exercise this discretion, so a vendor that does not respond to all mandatory requirements does so at its risk.

4.2 Proposal Scoring

Accepted Proposals will be reviewed by an evaluation committee and scored against the stated criteria. A Proposer may not contact any member of an evaluation committee except at the State's direction. The committee may review references, request interviews, and/or conduct on-site visits and use the results in scoring the Proposals. Proposals from certified Minority Business Enterprises may have points weighted by a factor of 1.00 to 1.05 to provide up to a five percent (5%) preference to these businesses (Wis. Stats. 16.75(3m)). The evaluation committee's scoring will be tabulated and Proposals ranked based on the numerical scores received.

The Cost Proposals will be calculated with the most points awarded to the Proposal with the lowest cost. Other Cost Proposals will be assigned points that correlate to those assigned to the lowest Cost Proposal.

4.3 Evaluation Criteria

The Proposals will be scored using the following criteria:

DESCRIPTION	PERCENT
Technical requirements	50%
A. Previous Medicaid managed care experience	A. 60%
B. Proposed quality performance strategy	B. 32%
C. Medical home pilot strategy	C. 8%
Cost	50%
TOTAL	100%
<i>Optional: Integrated Delivery System requirements</i>	<i>Up to 5% extra</i>

Proposers are not required to respond to the section on Integrated Delivery System requirements (Section 7 of this RFP). Proposers who choose to respond to this section, however, may receive up to 5% additional points, based on their responses to this section, which will be added to their overall total score.

4.4 Right to Reject Proposals and Negotiate Contract Terms

The State reserves the right to reject any and all Proposals. The State may negotiate the terms of the contract, including the award amount, with the selected Proposer(s) prior to entering into a contract. If contract negotiations cannot be concluded successfully with the highest scoring Proposer(s), the agency may negotiate a contract with the next highest scoring Proposer(s).

4.5 Award and Final Offers

The State will compile the final composite scores (Technical and Cost and IDS if applicable) for each Proposal. The award will be granted in one of two ways. The award may be granted to the highest scoring responsive and responsible Proposers. Alternatively, the highest scoring Proposer or Proposers may be requested to submit final and best offers. If final and best offers are requested by the State and submitted by the vendor, they will be evaluated against the stated criteria, scored and ranked by the evaluation committee. The award then will be granted to the highest scoring Proposers. However, a Proposer should not expect that the State will request a final and best offer.

A minimum of three Proposers with the best-evaluated Proposals will be eligible for a contract as a result of the RFP. If deemed to be in the best interest of the State, additional contracts may be awarded to one or more Proposals that fall within five (5) percentage points of the third-highest scoring Proposal, or if additional plans are needed to ensure all members can access managed care services.

As a condition of the State issuing a contract, HMOs must complete the below three steps to the satisfaction of the Department. HMOs will have approximately two months to complete these steps:

1. Provide evidence that the HMO has a valid Certificate of Authority (COA) and a Certificate of Incorporation (COI) issued by Wisconsin's Office of the Commissioner of Insurance (OCI).
2. Submit a full and complete provider network and facility report that details the Medicaid-certified providers who are contracted with the HMO to provide contract services to BadgerCare Plus members.
 - a. The provider network must meet the requirements stated in Art. III, H of the BadgerCare Plus Contract (Appendix A to this RFP) in order to be considered sufficient, and the provider network must be submitted according to the technical specifications found in Appendix D.
 - b. Copies of all provider contracts at the time must be submitted indicating the provider has contracted with the HMO to provide contracted services to BadgerCare Plus members.
3. Meet all certification requirements outlined in Appendix C.

If all of the above steps are met, the Department will issue contracts to the successful HMOs. Such contract shall be substantially the same as found in Appendix A. However, the State reserves the right, at its sole discretion, to add terms and conditions or to revise the BadgerCare Plus Contract (Appendix A to this RFP) requirements in the State's best interests subsequent to

this RFP process. No such terms and conditions or revision of Contract/Agreement requirements shall materially affect the basis of Proposal evaluations or negatively impact the competitive nature of the RFP process.

For final contract award, the Proposers must sign and return the contract drawn by the State pursuant to this RFP no later than the Contract Signature Deadline date detailed in Section 1 of this RFP or a later date as determined by the State.

4.6 Notification of Intent to Award

All vendors who respond to this RFP will be notified in writing of the State's intent to award the contract(s) as a result of this RFP.

After notification of the intent to award is made, and under the supervision of agency staff, copies of Proposals will be available for public inspection from 8:00 AM to 4:30 PM. CST at One West Wilson Street, Madison, Wisconsin. Vendors should schedule reviews with Susan McKercher at (608) 267-7637.

4.7 Appeals Process

Notices of intent to protest and protests must be made in writing to the Secretary of DHS. Protestors should make their protests as specific as possible and should identify statutes and Wisconsin Administrative Code provisions that are alleged to have been violated.

Any written notice of intent to protest the intent to award a contract must be filed with:

Karen Timberlake, Secretary
Department of Health Services
One West Wilson Street
PO Box 7850
Madison, WI 53701-7850

The notice of intent to protest the intent to award a contract must be received in her office no later than five (5) working days after the notices of intent to award are issued.

Any written protest must be received within ten (10) working days after the notice of intent to award is issued.

The decision of the Secretary of Department of Health Services may be appealed to the Secretary of the Department of Administration within five (5) working days of issuance, with a copy of such appeal filed with the Department of Health Services. The appeal must allege a violation of a Wisconsin statute or a section of the Wisconsin Administrative Code.

SECTION 5: MANDATORY PROPOSAL REQUIREMENTS

The following requirements are required components of the RFP. Failure of a Proposer to meet these requirements will result in exclusion from additional consideration unless the State exercises its discretion under Section 4.

#	Description
MANDATORY REQUIREMENTS	
1	<p>Complete application. Application must meet the specifications outlined in Section 3 of the RFP document. Failure to meet any of the specifications will result in exclusion from additional consideration.</p>
2	<p>OCI license. Provide evidence that you have a valid Certificate of Authority (COA) and a Certificate of Incorporation (COI) issued by Wisconsin’s Office of the Commissioner of Insurance (OCI).</p> <ul style="list-style-type: none"> • At the time of RFP submission, HMOs may provide proof that applications for a COA and COI have been submitted to OCI. However, HMOs will be required to provide evidence that a COA and COI have been obtained as a condition of signing a contract with the State. <ul style="list-style-type: none"> ○ Evidence of application must take the form of a signed letter the HMO has obtained from OCI indicating application materials have been submitted. ○ Evidence of securing the licenses must take the form of a signed letter the HMO has obtained from OCI indicating the licenses have been received. • If evidence of application for a COA and COI are not free of conditions or qualifications related to providing services to the Medicaid population, the HMO will be excluded from additional consideration.
3	<p>Provider network. Submit a full and complete provider network and facility report that details the providers, hospitals and urgent care clinics that are contracted with the HMO to provide contract services to BadgerCare Plus members.</p> <ul style="list-style-type: none"> • The provider network must meet all requirements stated in Art. III, H of the BadgerCare Plus Contract (Appendix A to this RFP) in order to be considered sufficient. <ul style="list-style-type: none"> ○ To evaluate whether the provider network meets the provider to member ratio requirements in Art. III, H.7 of the BadgerCare Plus Contract (Appendix A to this RFP), the Department will use the maximum enrollment level the HMO indicates in response to #5 below (in this section) as a proxy for “members.” If an HMO chooses to indicate unlimited number of members as the maximum enrollment level, the Department will use 70% of total members enrolled in the BadgerCare Plus program as of December 2009 as a proxy. • The provider network must be submitted according to the technical specifications found in Appendix D of the RFP. • Copies of all contracts with providers, hospitals, and urgent care clinics must be submitted indicating the provider has contracted with the HMO to provide contracted services to BadgerCare Plus members. At the time of RFP submission, HMOs may submit letters of intent with its provider network indicating the providers agree to contract with the HMO upon award of the RFP; however, HMOs will be required to

	<p>provide copies of the signed contracts it holds with its complete provider network at that point in time as a condition of signing a contract with the State.</p> <ul style="list-style-type: none"> • No less than 75% of the providers within the HMO’s submitted network must be Medicaid certified by the date the network is submitted. All providers in the network must be Medicaid certified when the HMO submits its final provider network prior to signing a contract with the State. • Failure to submit a provider network that meets the requirements stated in Art. III, H of the BadgerCare Plus Contract (Appendix A to this RFP) and technical specifications found in Appendix D will result in exclusion from additional consideration.
4	<p>References. Submit the name, title, address, email, and telephone number of contact person for each Medicaid/SCHIP contract held within the last five years as indicated in #2A (in Section 6 below) using the attached form DOA-3478. If you have not held a Medicaid/SCHIP contract within the last five years, submit contacts for large similar government or large private industry contracts that were held during this time period as indicated in #2A (in Section 6 below). Included in this list must be contact information for at least one contract which has ended preferably within the past 3 years. Include a brief description of each contract using supplemental pages as attachments to the DOA-3478.</p> <p>The Department will determine which, if any, references to contact to assess the quality of work performed and personnel assigned to the project. Failure to submit contact information for all applicable contracts mentioned above will result in exclusion from additional consideration.</p>
5	<p>Maximum enrollment level. The HMO must designate a maximum enrollment level for the entire RFP region on the form provided in Appendix F.</p> <ul style="list-style-type: none"> • This enrollment level must be no less than 25,000 BadgerCare Plus members. • The HMO may indicate unlimited number of members as the maximum enrollment level. • The HMO must have the capacity to provide services in accordance with the BadgerCare Plus Contract (Appendix A to this RFP) to the maximum enrollment level indicated in all areas served by this RFP. • If the HMO is awarded a contract, the HMO’s indicated maximum enrollment level will be fixed for approximately the first 18 months of the contract. After then, the maximum enrollment level may be increased or decreased based on mutual acceptance between the Department and the HMO of a different maximum enrollment level. See Art. VIII, B in the BadgerCare Plus Contract (Appendix A to this RFP) for more information. • Failure to submit the completed form in Appendix F will result in exclusion from additional consideration.

SECTION 6: TECHNICAL REQUIREMENTS

Proposers will be scored based on their responses in the following three areas in this section. The share of points under these technical requirements that will be allocated to each area is indicated in parentheses:

- A. Previous Medicaid managed care experience: organizational capabilities and quality performance (60%)
- B. Proposed quality performance strategy (32%)
- C. Medical home pilot strategy (8%)

6.1 Previous Medicaid Managed Care Experience (60%)—Limit of 100 pages

Proposers will be evaluated based on their demonstrated ability to manage and provide high-quality health care to a Medicaid population in similar metropolitan statistical areas to that of Milwaukee-Waukesha-West Allis (Milwaukee, Waukesha, Ozaukee and Washington), Racine (Racine), and Chicago-Naperville-Joliet (Kenosha). Specifically, in this section Proposers will be scored according to their organizational capabilities and demonstrated ability to manage a Medicaid population through a managed care delivery system, as well as their demonstrated ability to meet quality benchmarks and ensure members receive high-quality care appropriate for their needs.

#	Description
	ORGANIZATIONAL CAPABILITIES: Demonstrated ability to manage a Medicaid population through a managed care delivery system.
1A	<p>Description of organization. Describe your organization’s number of employees, client base, and location of offices. Include information on parent organization, affiliates, and subsidiaries.</p> <ul style="list-style-type: none"> • List the names and addresses of all persons (individual and/or corporate) who have a controlling interest in the HMO. List the names and addresses of all employees, vendors, or providers in which the HMO has a controlling interest or ownership. <ul style="list-style-type: none"> ○ As defined by CMS, “Controlling Interest” includes, but is not limited to, all owners, creditors, controlling officers, administrators, mortgage interest holders, employees or stockholders with holdings of 5 percent or greater of outstanding stock, or holders with such position or relationship who may have a bearing on the operation or administration of a medical service-related business. See Art. XVI of the BadgerCare Plus Contract (Appendix A to this RFP) for a comprehensive definition. ○ Indicate if the HMO (including any employee, vendors, or providers) in whom the HMO has a controlling interest, or any individual having a controlling interest in the HMO, since the inception of the Medicare, Medicaid, or Title XX services program, has been convicted of a crime related to, or been terminated from, a federal-assisted or state-assisted medical program. • Provide a narrative description of the proposed project team for managing the Wisconsin Medicaid account, its members and organizational structure.

	<ul style="list-style-type: none"> • Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the contract as well as an organizational chart highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. For key staff positions that are not currently filled, please provide job descriptions, including qualifications and duties, and an indication of when the position will be filled. Indicate the city and state in which the key staff will be based (i.e., conduct more than 50% of their work). • Provide a statement of whether you intend to use subcontractors and if so, a clear estimation of what percentage of the BadgerCare Plus Contract (Appendix A to this RFP) will be subcontracted. Specifically comment on whether you intend to use a subcontractor for behavioral health services. <ul style="list-style-type: none"> ○ Include the names and mailing addresses of the subcontractors and a description of the scope and portions of the work the subcontractors will perform. Indicate the city and state from which they will perform the work. ○ Specify whether any of the subcontractors are currently providing services for you in other states and where the subcontractors are located. ○ Describe how you intend to monitor and evaluate subcontractor performance.
2A	<p>Managed care contracts.</p> <ol style="list-style-type: none"> 1) Identify all publicly-funded managed care contracts for Medicaid/SCHIP and/or other low-income individuals within the last five years. Include parent organization, affiliates, subsidiaries, and subcontractors that held 20% or more of a contract's scope of responsibility. If you have not held a Medicaid/SCHIP contract within the last five years, identify all large similar government or large private industry contracts that were held during this time period. 2) Identify the five largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/SCHIP and/or other low-income individuals within the last five years. Include parent organization, affiliates, subsidiaries, and subcontractors that held 20% or more of a contract's scope of responsibility. <ul style="list-style-type: none"> ▪ For each contract identified in 1) and 2) provide: <ul style="list-style-type: none"> ○ Contact name and phone number. ○ Brief description of the scope of work and services provider. Highlight any services provided similar to those outlined in this RFP. ○ Dates of the contract. ○ Number of members and the population types (e.g., TANF, EBD, duals, SCHIP). ○ Annual contract payments. ○ Whether payment was capitated or other. ○ Role of subcontractors, if any. ▪ For each contract indicate if any of the following occurred and provide the primary contact information, including the name, telephone and email, for the agency that proposed and/or assessed the below regulatory action(s): <ul style="list-style-type: none"> ○ <u>Suspension of New Enrollment</u>—Indicate if enrollment of new members into the HMO was stopped, reduced or suspended by action of a governmental body for reasons related to poor/unacceptable performance in delivering services or failure to comply with contractual agreements. If such action occurred, describe the related circumstances, length of time this action applied, and the current status of

	<p>the action.</p> <ul style="list-style-type: none"> ○ <u>Proposed Contract Termination/Non-renewal</u>—Indicate if a state or the federal government proposed in a written/typed communication to terminate or not renew its contract with the Proposer for reasons related to negative performance or failure to comply with contractual agreements. If such action occurred, describe the related circumstances and the current status of the action. ○ <u>Contract Denial/Termination/Non-renewal</u>—Indicate if a state or the federal government initiated and executed a termination or non-renewal of its contract with the Proposer for reasons related to negative performance or failure to comply with contractual agreements. If such action occurred, describe the related circumstances and the current status of the action.
3A	<p>Claims management and encounter data processing.</p> <ul style="list-style-type: none"> • Describe the capabilities of your claims payment and encounter data reporting systems as they relate to Article VII of the BadgerCare Plus Contract (Appendix A to this RFP), in particular with reference to ensuring timely and accurate encounter claim processing, payment and reporting. Address whether and how your systems will meet (or exceed) the contractual requirements. • Provide example(s) of claims payment and encounter data reporting systems the HMO has implemented in other states, including descriptions of system functionality and the capacity to meet timely payment and accuracy standards.
QUALITY PERFORMANCE: Demonstrated ability to meet quality benchmarks and ensure members receive high-quality care appropriate for their needs.	
4A	<p>HEDIS data. For each of the Medicaid populations for which you have or have had a contract as indicated in #2A, provide in a table format HEDIS data for 2006-08 for the following measures:</p> <ul style="list-style-type: none"> ○ Childhood Immunization status ○ Blood Lead testing of 1 and 2 year olds ○ Use of Appropriate Medications for People with Asthma ○ Comprehensive Diabetes care: HbA1C Testing and LDL-C Screening • If you do not have results for a particular measure or year, please provide the results you do have and explain why certain data is not available. If data is not available for your Medicaid population, please submit commercial data in that state and explain why Medicaid data is not available. • Data must be accompanied by a statement of certification from an NCQA-certified auditor.
5A	<p>CAHPS/member satisfaction data. For each of the Medicaid populations for which you have or have had a contract as indicated in #2A, provide in a table format CAHPS satisfaction measures for 2006-08 for the following measures:</p> <ul style="list-style-type: none"> ○ Rating of Health Plan ○ Getting Needed Care ○ Getting Care Quickly • If CAHPS data is not available, please provide results from another member satisfaction survey you issued. For another member satisfaction survey, include:

	<ul style="list-style-type: none"> ○ Overall response rate to the survey ○ How the survey was administered (telephone, mail, etc.) ○ Ratings scale response options ○ Text for the survey questions ● If you do not have results for a particular measure or year, please provide the results you do have and explain why certain data is not available. If data is not available for your Medicaid population, please submit commercial data in that state and explain why Medicaid data is not available. ● Data must be accompanied by a statement of certification from an NCQA-certified auditor.
6A	Previous strategy—HEDIS. Describe your experience using HEDIS measures for the Medicaid populations for which you have or have had a contract as indicated in #2A as a monitoring and quality improvement tool to evaluate clinical performance of the care members received. Include in your description information on the strategy used for achieving the HEDIS performance levels indicated in your response to #4A. Include information on how you identified members with specific conditions; outreach strategies to members; how providers were engaged; and internal evaluations performed. Describe any barriers or impediments you encountered in implementing your strategy and what improvement strategies you undertook to address them.
7A	Previous strategy—Member satisfaction. Describe your strategy implemented in the Medicaid populations for which you have or have had a contract as indicated in #2A for ensuring high-quality customer service was provided to members. Include information on how you solicited member feedback and examples of initiatives implemented in response to member feedback. Describe any barriers or impediments you encountered in implementing your strategy and what improvement strategies you undertook to address them.
8A	Previous strategy—Emergency Department (ED) Utilization Management. Describe any activities implemented in the Medicaid populations for which you have or have had a contract as indicated in #2A related to ED Utilization Management, such as but not restricted to, member incentives, improving access to and emphasizing primary care, care management programs for high-volume ED users, and the use of information systems to identify high utilizers of target ED services. Provide information on how you evaluated these activities as well as data to support the outcomes of your activities. Describe any barriers or impediments you encountered in implementing your strategy and what improvement strategies you undertook to address them.
9A	Previous strategy—Dental. Describe your initiatives implemented in the Medicaid populations for which you have or have had a contract as indicated in #2A related to increasing dental utilization among members. Provide information regarding provider participation (including pediatric dental providers, orthodontists and oral surgeons), member outreach, appointment time standards, and coordination of dental services for members. Describe how you evaluated these activities as well as data to support the outcomes of your activities. Describe any barriers or impediments you encountered in

	implementing your strategy and what improvement strategies you undertook to address them.
10A	Previous strategy—Tobacco Cessation. Describe your activities implemented in the Medicaid populations for which you have or have had a contract as indicated in #2A related to tobacco cessation. Provide information on how you evaluated these activities as well as data to support the outcomes of your activities. Describe any barriers or impediments you encountered in implementing your strategy and what improvement strategies you undertook to address them.
11A	Previous strategy—Managing chronic conditions. Describe your approach used in the Medicaid populations for which you have or have had a contract as indicated in #2A for managing the care of members with chronic conditions, including but not limited to diabetes, asthma, COPD, congestive heart failure, and behavioral health/mental illness for adults; as well as diabetes, asthma, and behavioral health/mental illness for children. Include in your description your approach for also managing members with co-morbidity conditions. <ul style="list-style-type: none"> • Include information on how you engaged both members and providers. • Provide information on how you evaluated these approaches as well as data to support the effectiveness of your approaches. • Describe any barriers or impediments you encountered in implementing your strategy and what improvement strategies you undertook to address them.
12A	Previous strategy—Reducing poor birth outcomes. Describe any initiatives you have implemented for the Medicaid populations for which you have or have had a contract as indicated in #2A that were targeted at high-risk pregnant women for reducing poor birth outcomes. Include in the description: <ul style="list-style-type: none"> • Target population and size of participating population group. • Evidence of your ability to implement an initiative targeted at high-risk pregnant women successfully including, but not limited to, performance measures. • Overall outcomes of the initiatives, including birth outcome data. • A description of any barriers or impediments you encountered in implementing the initiatives and what improvement strategies you undertook to address them.
13A	Previous strategy—Overall. Describe your strategy for facilitating access to all needed services by your members in the Medicaid populations for which you have or have had a contract as indicated in #2A in a way that promotes prevention, wellness and appropriate utilization of services. Provide specific examples of activities you implemented to meet the objectives of your strategy. <ul style="list-style-type: none"> • Include examples of how providers are engaged to accomplish these objectives. Describe the role medical homes have played as part of your strategy. • Include examples of community health improvement activities you have engaged in with the communities in which the Medicaid programs have operated, including any collaborative partnerships you formed with medical and non-medical community-based organizations. • Include examples of how services are made accessible to your members of limited

	<p>English language skills and the people with disabilities.</p> <ul style="list-style-type: none"> • Describe any barriers or impediments you encountered in implementing your strategy and what improvement strategies you undertook to address them. • Do not state examples already addressed in previous sections of your response.
14A	<p>Cultural awareness. Describe how you incorporated cultural awareness within your organization and in the delivery of care to your members in the Medicaid populations for which you have or have had a contract as indicated in #2A. In your description, address the following components including examples of how these components were operationalized by your organization:</p> <ol style="list-style-type: none"> 1. Created and sustained an environment of cultural awareness through establishing leadership structures and systems or embedded them into existing structures and systems. 2. Created written policies, practices, procedures, and programs of culturally competent approaches, and disseminated and monitored this information on an ongoing basis at the provider level. 3. Maintained sufficient resources for communicating with patients in their primary written and spoken languages (including American Sign Language) through qualified/competent interpreter resources to ensure timely and high-quality communication. 4. Developed a list of vital documents and translated them into appropriate languages or have established a process to provide access to vital information. 5. Received and utilized feedback from individuals specifically targeting relevant differences, such as race/ethnicity, gender and sexual orientation in the planning, design and evaluation of culturally competent care. <ul style="list-style-type: none"> • Describe how these policies were enforced among subcontractors. • Describe any barriers or impediments you encountered in implementing your strategy and what improvement strategies you undertook to address them.

6.2 Proposed Quality Performance Strategy (32%)—Limit of 75 pages

Proposers will be evaluated based on their proposed strategies for meeting the performance benchmarks and requirements DHS has established in the BadgerCare Plus Contract (Appendix A to this RFP) and for ensuring members receive high-quality care appropriate for their needs.

For each section below, in addition to responding to the criteria listed, Proposers must indicate:

1. Which of the strategies that the Proposer identified in Section 6.1 (Previous Medicaid Managed Care Experience) the Proposer plans to replicate, adapt, or implement as part of its approach with the BadgerCare Plus Contract (Appendix A to this RFP); and
2. What new or innovative strategies the Proposer plans to introduce specific to the BadgerCare Plus population.

#	Description
PROPOSED QUALITY PERFORMANCE STRATEGY	
1B	<p>Overall strategy. Describe the strategy you propose for facilitating access to all needed services by members in a way that promotes prevention, wellness and appropriate utilization of services. Provide specific examples of activities you will undertake to meet the objectives of your strategy. Include examples of how providers and subcontractors will be engaged to accomplish these objectives; how you plan to incorporate cultural awareness, language assistance and disability accommodations within your organization and in the delivery of care to your BadgerCare Plus members; and the community health improvement activities you plan to engage in, including any collaborative partnerships you plan to form with community-based organizations.</p> <ul style="list-style-type: none"> • Indicate additional services you will provide to members above and beyond what is required in the BadgerCare Plus Contract (Appendix A to this RFP). Information on these services will be shared with members during the enrollment period. • Indicate how you plan to evaluate the effectiveness of your strategy.
2B	<p>Quality Performance Goals. Describe the approach you propose to take for meeting DHS performance benchmarks for each of the following measures as indicated in Addendum VI of the contract:</p> <ul style="list-style-type: none"> ○ Childhood Immunization status ○ Blood Lead testing of 1 and 2 year olds ○ Use of Appropriate Medications for People with Asthma ○ Comprehensive Diabetes care: HbA1C Testing and LDL-C Screening ○ Tobacco cessation • Include in your description activities related to provider incentives (financial or non-financial), provider training and monitoring, member interventions, outreach and education targeted to each measure, and internal evaluation of the effectiveness of these activities.
3B	<p>Emergency Department Utilization Management Plan. Describe the plan you propose for managing members’ use of emergency departments (ED) for medical care and for meeting DHS performance benchmarks on ED utilization management as indicated in</p>

	<p>Addendum VI, A.2 of the BadgerCare Plus Contract (Appendix A to this RFP). Include in the plan details on:</p> <ul style="list-style-type: none"> ○ A strategy to reduce the rate of ED visits per member; ○ A strategy to reduce the percent of members with three or more ED visits and no primary care provider visit within a 12 month period; ○ A strategy to reduce the rate of ED visits for an ambulatory sensitive condition; and ○ A process that seeks out feedback and recommendations from EDs within your service area. <ul style="list-style-type: none"> ● Include information on activities related to member incentives, improving access to and emphasizing primary care, care management programs for high-volume ED users, the use of information systems to identify high users of target ED services, and internal evaluation of the effectiveness of these activities.
<p>4B</p>	<p>Primary Care Management. Describe the approach you propose for primary care management of the BadgerCare Plus population. In this Proposal, the HMO should address:</p> <ul style="list-style-type: none"> ● Process for assigning all members to a primary care provider. ● Process for identifying members with the following chronic conditions: diabetes, asthma, COPD, congestive heart failure, and behavioral health/mental illness for adults, as well as diabetes, asthma, and behavioral health/mental illness for children. Indicate how clinical guidelines and decision making tools will be used in this process. <ul style="list-style-type: none"> ○ Process for assigning members with these chronic conditions to an appropriate primary care provider (or specialist) and ensuring care will be coordinated between primary care provider and specialists. ○ For members with these chronic conditions, process for ensuring a treatment plan, which includes a self-care component, is developed between the member and their assigned primary care physician and specialists and that the treatment plan is followed. ● Process for communicating with members about their primary care provider assignment, ensuring/encouraging members to use their assigned provider, and ensuring/encouraging members to keep their scheduled appointments. ● Process for providing information on members to their primary care provider on a monthly basis, including utilization data and prescription drug data such as from the DHS pharmacy extract. ● Whether the HMO will provide an enhanced reimbursement rate to primary care provider practices that function as a medical home, and if so, describe what criteria the HMO will use to identify a medical home, how the enhanced reimbursement rate will be implemented, and the HMO's process for evaluating practices annually as to whether they meet the criteria. ● How the HMO will evaluate its primary care provider assignment strategy as well as its strategy for providing care management to members with chronic conditions, specifically focusing on: <ul style="list-style-type: none"> ○ The quality of care members receive; ○ Members' compliance with using their assigned primary care provider;

	<ul style="list-style-type: none"> ○ Members who miss their scheduled appointments; and ○ Members who receive care for primary care treatable conditions through their primary care provider versus through the emergency department.
5B	Monitoring provider network. Describe the process you propose to implement for monitoring your provider network to ensure it is adequate in size and scope to meet the needs of the BadgerCare Plus population. The description must include how you will plan to hold your provider network accountable to standards outlined in Art. III, H in the BadgerCare Plus Contract (Appendix A to this RFP) including those based on geographic distance, waiting times for care and appointments, and provider to member ratios.
6B	Access to dental services. Describe your proposed strategy for ensuring access to dental services among BadgerCare Plus members and for meeting DHS performance benchmarks as indicated in Addendum VI of the contract in Appendix A. The strategy must address the following: <ul style="list-style-type: none"> ● Provider participation (including pediatric dental providers, orthodontists and oral surgeons); ● Member outreach; ● Appointment time standards; ● Coordination of dental services for members; ● A strategy to increase utilization rates for the BadgerCare Plus population, including use of preventive services, comprehensive care, and emergency services; and ● An internal evaluation of the effectiveness of the strategy.
7B	Reducing poor birth outcomes. Describe your proposed strategy for meeting DHS performance benchmarks for reducing poor birth outcomes among high-risk pregnant women as indicated in Addendum VI of the BadgerCare Plus Contract (Appendix A to this RFP). The strategy must address how you will also meet the requirements indicated in Article IV, K of the BadgerCare Plus Contract (Appendix A to this RFP), including how you plan to identify women at high-risk of a poor birth outcome and ensure these members receive appropriate care. Describe how you will internally evaluate the effectiveness of the strategy <ul style="list-style-type: none"> ● This strategy must be specific to the high-risk pregnant women who <u>are not</u> participants in the medical home pilot described in Section C of the RFP and Art. III, R in the BadgerCare Plus Contract (Appendix A to this RFP).

6.3 Medical Home Pilot Strategy (8%)—*Limit of 25 pages*

6.3.1 Overview of Medical Home Pilot Strategy

Proposers will be evaluated based on their demonstrated ability in and proposed strategy for implementing a medical home pilot for high-risk pregnant women. Specific requirements the

medical home pilot must meet are listed in Article III, R of the BadgerCare Plus Contract (Appendix A to this RFP). Additional information on how the Department defines a medical home is below.

6.3.2 Background

One of the Department’s priorities is to ensure every baby in the State is born healthy. Over the past decade, the Department has led a number of initiatives to this effect, including implementing efforts to expand eligibility for pregnant women and Prenatal Care Coordination (PNCC) agencies. Despite these efforts, the Southeastern region of WI has exhibited a disproportionately higher rate infant mortality compared with the rest of the State:

Region	Deaths per 1,000 Births (2006)
Southeastern	7.9
Southern	5.48
Northeastern	6.16
Western	5.68
Northern	5.54

Source: Wisconsin Department of Health Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH) data query system, <http://dhfs.wisconsin.gov/wish/>, Prenatal Care Module, accessed 4/1/08

The Department believes that by ensuring women with high-risk pregnancies receive appropriate care, the infant mortality rate can be positively impacted. A medical home model that has a patient-centered approach and strives to provide comprehensive care to the member is well positioned to address the multi-faceted issue of high-risk pregnancies leading to a decrease in the number of infant deaths in this region of the State. Chronic diseases, the lack of access to services as well as the lack of continuity and timeliness of care are all factors that can adversely affect the outcome of a pregnancy. The Medical Home accounts for these factors and can benefit pregnant women who are at risk of having a poor birth outcome.

A Medical Home is an approach to providing health care services in a high quality and cost effective manner. In a Medical Home, patients and families are engaged as partners; mechanisms are in place to identify high risk pregnant women within the practice, care is coordinated in a systematic way, and patients are linked to community supports and services. The care that is provided is accessible, patient-centered, continuous, comprehensive, coordinated, compassionate and culturally effective (including the provision of language assistance). Through the Medical Home, providers and staff strive to improve health outcomes, enhance the quality of life for patients and families, and provide more cost-effective care.

Each participating member in the Medical Home will have an ongoing relationship with a qualified provider who leads a team (may include nurses, care coordinators, health navigators, or health educators) that together takes responsibility for the care of the patient. The Medical Home will provide for all the pregnant woman’s health care needs or will arrange care with other

qualified professionals—including acute care, chronic care, preventive services and patient counseling. Care will be provided in locations convenient and accessible to the patient 24/7.

To be patient-centered, the provider must share complete and unbiased information with the patient on an ongoing basis. Care will be coordinated across the health care system (including subspecialty care, hospitals, and public health agencies). The Medical Home team will systematically track tests, referrals, and results and then share this information with the patient. To be effective, the patient’s cultural background will be recognized and incorporated into the care plan and efforts will be made to ensure that the patient understands the medical results and the care plan, including use of translators, interpreters, or written materials in patient’s primary language.

Quality and safety will be ensured via the use of care plans to identify patient-centered outcome goals, use of evidence-based medicine to guide medical decision making about the woman’s pregnancy and chronic conditions, active participation of patients in decision making, utilization of information technology to support patient care including preventive services and chronic disease management, performance review, patient education and communication.

6.3.3 Evaluation Criteria

Proposers must respond to the criteria listed below. In preparing their response, Proposers should reference the specific requirements the medical home pilot must meet which are listed in Article III, R of the BadgerCare Plus Contract (Appendix A to this RFP).

#	Description
MEDICAL HOME PILOT STRATEGY	
1C	<p>Previous experience—medical home model. Describe all previous experience you have had with Medical Home model implementation. Include in the description:</p> <ul style="list-style-type: none"> • Target population and size of participating population group. • Specific references to components detailed in Article III, R in the BadgerCare Plus Contract (Appendix A to this RFP). Evidence of your ability to implement a medical home model successfully including, but not limited to, performance measures such as HEDIS measures, AHRQ’s Prevention Quality Indicators (PQIs), and CAHPS data over a delivery period of at least three years.
2C	<p>Medical home pilot strategy. Describe your proposed strategy for implementing the Medical Home pilot detailed in Article III, R in the BadgerCare Plus Contract (Appendix A to this RFP). The description must include the following components:</p> <ul style="list-style-type: none"> • Strategies to recruit and retain members to participate in the Medical Home pilot. • Strategy for partnering with a clinic to implement the Medical Home pilot and ensuring that the clinic is capable of functioning as such by fulfilling criteria in Article III, R, 2. Vendors must submit the names and contact information for three clinics that you would potentially partner with to implement this model. • Plan to ensure care coordination services at Medical Home sites. • How the activities the care coordinator will undertake will support promotion of a healthy birth outcome.

	<p>Indicate in your response the individual who will be responsible for overseeing the execution of the medical home pilot. Attach a resume for this individual as well as an organizational chart highlighting this individual's placement among the lines of authority. Indicate the city and state in which this individual will be based (i.e., conduct more than 50% of their work).</p>
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SECTION 7: OPTIONAL REQUIREMENTS—*Limit of 10 pages*

NOTE: Proposers are not required to respond to this section.

7.1 Overview of Integrated Delivery System Requirements

Proposers who choose to respond to this section will be evaluated on the extent to which their organizational structure reflects that of an Integrated Delivery System (IDS). Organizing as an IDS is not a requirement to participate in the BadgerCare Plus program; however the Department would like to encourage the participation of HMOs that are an IDS or plan to function as an IDS in the RFP region. Those HMOs that respond to this section may receive up to 5% additional points on top of their overall total score.

7.2 Background

The Department acknowledges that the integration of health care services is an important factor in delivering high-quality, cost-effective, accessible and patient-focused care. According to the Commonwealth Fund, there are six attributes of an ideal health system that an IDS addresses:¹

1. Information continuity, e.g., through electronic medical records;
2. Care coordination and transitions among multiple providers and care settings;
3. Clear system accountability for the total care of patients;
4. Peer review and teamwork for high-value care, where providers within and across settings are accountable to each other, review each other's work and collaborate to deliver care;
5. Continuous innovation to improve the quality, value and patient's experience; and
6. Easy access to appropriate care, with multiple points of entry to the system, and with culturally competent and responsive providers.

The Department wishes to encourage IDS and the overall integration of health care services in Southeast Wisconsin. Those HMOs who are organized as an IDS or meet the attributes of an IDS may be eligible for additional points towards their overall RFP score.

An IDS is a health care delivery system with its own hospitals and/or a multi-specialty physician group practice and a health plan. The IDS delivery model holds the organization financially at risk to provide health care services to a defined population and held clinically accountable for the outcomes and health status of the population served. The insurance function provides flexibility, aligned incentives, and expertise in organizing to deliver high-value care. The models may be "closed", such as Kaiser Health Plan, or "open," serving patients both within and outside their health plans, or mixed model health plans that include both an integrated medical group and independent physicians in private practice.

¹ See: <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2008/Aug/Organizing-the-U-S--Health-Care-Delivery-System-for-High-Performance.aspx>

7.3 Evaluation Criteria

If a Proposer chooses to respond to this Section, the Proposer must, at a minimum, respond to A and C below. The Proposer may respond to B, but a response to B is not required. If the Proposer responds to B, the Proposer's response will be scored and included in the total score for this Section.

- A. The Proposer must describe how it fits the definition of an IDS, as well as how it functions and is organized to meet each of the six attributes listed in the Background above in the RFP region. In addressing these six attributes, the Proposer must include a brief description on how it meets all of the 9 elements listed below under "Elements of an IDS." The Proposer must reference each element by including its corresponding number when addressing the element in its response.

The 9 "Elements of an IDS" represent the Department's minimum characteristics needed to be considered an IDS in the RFP region. Proposers must meet at least all of the minimum characteristics in order to be eligible for any points associated with this section. Proposers that meet these minimum characteristics will receive the minimum number of points available in this section. To receive more than the minimum number of points, the Proposer must also demonstrate that it employs heightened integration in this area and an ability to apply it beyond the stated minimum characteristics.

Elements of an IDS:

1. The Proposer has a close relationship, including both strategic and financial, with a medical group located within the RFP area, whereby the medical group is measured on quality, cost, efficiency and effectiveness by the Proposer, and the Proposer uses data to collaborate with the medical group through strategic meetings to implement performance improvement and other similar initiatives based on standardized measures to change and improve the medical group's practices.
2. The Proposer has a close relationship, including both strategic and financial, with a hospital located within the RFP area, whereby the hospital is measured on quality, cost, efficiency and effectiveness by the Proposer, and the Proposer uses data to collaborate with the hospital through strategic meetings to implement performance improvement and other similar initiatives based on standardized measures to change and improve the hospital's practices.
3. The Proposer has a close relationship with urgent care clinics, including both strategic and financial, located within the RFP area, whereby the urgent care clinics are measured on quality, cost, efficiency and effectiveness by the Proposer, and the Proposer uses data to collaborate with urgent care clinics through strategic meetings to implement performance improvement and other similar initiatives based on standardized measures to change and improve the urgent care clinic's practices.
4. The Proposer has an operational nurseline that is available to members 24/7, 365 days a year.
5. The Proposer has a single Electronic Medical Records system or patient registry that is used among some, but not necessarily all, of the Proposer's clinics within the RFP area.

6. The Proposer measures clinical and administrative data and reports it on an ongoing basis and uses those measures to inform decisions.
 7. The Proposer has an operational wellness program (or similar program that is designed to maintain a member's health and wellbeing through activities that prevent acute and chronic illnesses) within the RFP area offered to all members and is actively measured and reported on by the Proposer.
 8. The Proposer has operational chronic disease management programs within the RFP area that are actively measured and reported on by the Proposer.
 9. The Proposer has an operational case management program within the RFP area that is actively measured and reported on by the Proposer.
- B. As part of the Proposer's response, the Proposer may choose to also address how it meets the below two measures. These two measures are not part of the minimum requirements stated in A; however, the Department feels they are important aspects of an IDS. The Proposer must meet all of the 9 elements in A in order for the response in B to be considered. If Proposer's response to these two measures is considered, the response will be evaluated and the score received will be added to the Proposer's total score for this section.
1. The Proposer uses a variety of technology tools (e.g. decision support tools) to improve quality of care and efficiency throughout the Proposer's clinics within the RFP area.
 2. The Proposer provides evidence that incentives are aligned so that quality outcomes and processes that benefit the member also benefit each part of the IDS.
- C. If a Proposer chooses to respond to A, the Proposer must submit signed letters of intent from any Medical Groups and Hospitals that are mentioned as part of the response to A. The letter of intent must demonstrate the Medical Group's or Hospital's understanding that it will plan to function as an IDS with the Proposer at a level that is equal to or greater than the minimum requirements listed in A. If the Proposer fails to provide adequate documentation regarding these letters of intent, it will fail to meet the requirements for this section of the RFP, and will not be eligible for any points related to the IDS section.

SECTION 8: COST PROPOSAL

8.1 General Instructions on Preparing Cost Proposals

The Cost Proposal must be submitted using the form in Appendix B. The form must be completed in its entirety and submitted in a separate envelope from the Technical Proposal as directed in Section 3. The Cost Proposal will be scored using a methodology in which the most points will be awarded to the Proposal with the lowest cost. The other Proposals will be awarded fewer points that will be calculated relative to the lowest cost. Fifty percent (50%) of total points will be allocated to the Vendor's Cost Proposal.

8.2 Format for Submitting Cost Proposal

As part of this RFP, Proposers must submit a Cost Proposal for the administrative costs associated with administering the BadgerCare Plus Standard and Benchmark Plans, in accordance with the BadgerCare Plus Contract (Appendix A to this RFP). The administrative costs should reflect the funding necessary for the HMO to cover the non-medical costs required of the BadgerCare Plus Contract (Appendix A to this RFP). The Cost Proposal must be submitted using the form in Appendix B.

Proposers must submit a single cost expressed as per member per month (PMPM) carried out to the second decimal point. If the HMO is awarded a contract through this RFP, the HMO will receive the fixed administrative cost submitted in the Cost Proposal each month for each member enrolled in the Proposers plan for the length of the contract. However, the Department may, at its sole discretion, adjust this administrative PMPM annually by no more than the Consumer Price Index (CPI).

Scoring considerations: cost amount and auto-assignment allocation

Fifty percent of total points for this RFP will be allocated to the Vendor's Cost Proposal. The lowest cost will receive the most points and the other Proposals will be awarded fewer points calculated relative to the lowest cost.

In addition, for HMOs who are awarded a contract through the RFP, the score the HMO receives on the Cost Proposal section of this RFP will determine the percentage of members automatically assigned to the HMO. Specifically, among the HMOs that are awarded the contract, the HMO with the lowest Cost Proposal will receive 60% of auto-assignments and the second lowest Cost Proposal will receive 25% of auto-assignments. The remaining 15% of auto-assignments will be allocated equally among the third lowest Cost Proposal and any additional HMOs that may be awarded a contract through the RFP. If any HMO reaches its enrollment cap before the allotted auto-assignments have been allocated to that HMO, the remaining auto-assignments will be given to the HMO with the next lowest Cost Proposal. Note that for BadgerCare Plus families, all members of a family will be automatically assigned to the same HMO.

This distribution of auto-assignments will remain intact until the Department has calculated the HMOs' performance on select quality measures—after approximately the first 18 months of the contract. After this data is available, new members will be auto-assigned to HMOs based on the HMOs' performance on the quality measures. (See Section 2 of this RFP for more information on how members will be assigned into HMOs.)

8.3 Background: Components of the Capitation Rate

In determining the Cost Proposal the HMO is to submit, the HMO should take into consideration the various components of the monthly base capitation payment amount, of which the administrative PMPM is an essential piece. Below is an overview of how the Department calculates the HMO's monthly base capitation payment, as well as additional information on each of the components that comprise this calculation. (Note the intent of the below information is to provide an overview not all details of the rate setting process. Comprehensive information on the rate setting process can be found in Appendix E and Art. VI of the BadgerCare Plus Contract (Appendix A to this RFP).

To calculate the HMO's monthly base capitation payment, the Department begins by determining the PMPM medical costs associated with the BadgerCare Plus Standard and Benchmark plans for non-maternity services by age, gender and region. The administrative PMPM amount is then added to these costs. The sum of the PMPM medical costs and administrative PMPM represents the base capitation rate. If sufficient data is available, this rate is then adjusted on an HMO specific basis for the chronicity of the HMOs population. Additionally, any access payments specific to that HMO are added to the adjusted rate. The end product is an HMO-specific capitation rate for non-maternity services.

Medical costs related to maternity services are reimbursed through a kick payment methodology. With the kick payment reimbursement methodology, the HMO receives a lump sum payment per identified delivery. The kick payment amount is determined by region and it is not adjusted for risk or age. Administrative expenses associated with maternity services will be paid as part of the base capitation payments and therefore the kick payments do not contain an administrative component.

$$\text{HMO-Specific Capitation Rate} = [(\text{PMPM Medical Costs} + \text{HMO-specific administrative PMPM}) * (\text{HMO specific chronicity score})] + \text{access payments} + \text{Maternity Kick Payments}$$

For HMOs providing services through this RFP only, beginning in CY 2011, 3.25% of the HMO-specific capitation rate (excluding access payments) will be held at-risk annually based on the HMO's performance in meeting the Department's quality performance benchmarks detailed in Addendum VI in BadgerCare Plus Contract (Appendix A to this RFP). Therefore, this amount will be subtracted from the total HMO-specific capitation payment and only paid out to the HMO if it successfully meets the quality performance benchmark criteria.

The Department ensures annually that the final capitation payments are actuarially sound and receives CMS approval that they were set in accordance with the requirements outlined in 42 CFR 438.6.

Medical Costs

The capitation rate-setting process begins with an assessment of the most recently available two calendar years of historical HMO utilization of medical services for the BadgerCare Plus Standard and Benchmark population. The anticipated medical costs are then determined by pricing the HMO data at Medicaid fee-for-service rates. These medical costs include inpatient, outpatient and professional services costs. The Department’s actuary assesses medical cost spending to ensure validity and uses the encounter data to set rates by age, gender, and rate region. Maternity costs are separated out from this assessment and included in the kick payment.

For each rate setting cycle, the Department makes financial adjustments to the pricing of the encounter data to reflect the anticipated costs to be incurred during the rate year. These adjustments may vary by year. For example, in the past, adjustments have been made for fee-for-service coverage and rate changes anticipated during the contract period, trend adjustments to claims data to anticipate future costs, and claims incurred but not reported (IBNR).

The medical cost PMPM rates determined by the Department for CY 2010 are listed below. These costs are reported according to rate region for the two rate regions affected by the RFP: Region 6: Milwaukee County; and Region 5: Washington, Ozaukee, Waukesha, Racine and Kenosha counties. Comprehensive information on CY 2010 rates can be found in Appendix E.

**CY 2010 Region 6 Standard Plan Medical Only PMPM Rates
(No administrative allowance included. Excludes access payments.)**

Age	Gender	Medical PMPM Payment	Chiropractic PMPM payment
Age 0	All	313.35	0.03
Ages 1-5	All	70.24	0.03
Ages 6-14	All	47.99	0.04
Ages 15-20	Female	94.76	0.09
Ages 15-20	Male	59.75	0.05
Ages 21-34	Female	151.63	0.24
Ages 21-34	Male	102.27	0.40
Ages 35-44	Female	211.10	0.32
Ages 35-44	Male	161.53	0.39
Ages 45 & Over	Female	278.62	0.46
Ages 45 & Over	Male	281.57	0.39

**CY 2010 Region 6 Standard Plan Medical Only Maternity Kick Payment
(No administrative allowance included. Excludes access payments.)**

	Medical PMPM Payment
All Ages	4,596.43

**CY 2010 Region 5 Standard Plan Medical Only PMPM Rates
(No administrative allowance included. Excludes access payments.)**

Age	Gender	Medical PMPM Payment	Chiropractic PMPM Payment
Age 0	All	241.17	0.19
Ages 1-5	All	57.53	0.17
Ages 6-14	All	47.34	0.34
Ages 15-20	Female	92.93	0.58
Ages 15-20	Male	66.93	0.46
Ages 21-34	Female	156.23	1.12
Ages 21-34	Male	108.87	1.13
Ages 35-44	Female	214.24	1.68
Ages 35-44	Male	159.36	1.32
Ages 45 & Over	Female	248.73	1.78
Ages 45 & Over	Male	213.51	1.37

**CY 2010 Region 5 Standard Plan Medical Only Maternity Kick Payment
(No administrative allowance included. Excludes access payments.)**

	Medical PMPM Payment
All Ages	3,659.71

**CY 2010 Region 6 Benchmark Plan Medical Only PMPM Rates
(No administrative allowance included. Excludes access payments.)**

Age	Gender	Medical PMPM Payment	Chiropractic PMPM Payment
Age 0	All	262.37	0.01
Ages 1-5	All	58.95	0.01
Ages 6-14	All	40.42	0.01
Ages 15-20	Female	79.54	0.02
Ages 15-20	Male	50.20	0.01
Ages 21-34	Female	146.80	0.06
Ages 21-34	Male	93.25	0.10
Ages 35-44	Female	204.39	0.08
Ages 35-44	Male	150.08	0.09
Ages 45 & Over	Female	269.76	0.11
Ages 45 & Over	Male	262.88	0.09

**CY 2010 Region 6 Benchmark Plan Medical Only Maternity Kick Payment
(No administrative allowance included. Excludes access payments.)**

	Medical PMPM Payment
All Ages	4,596.43

**CY 2010 Region 5 Benchmark Plan Medical Only PMPM Rates
(No administrative allowance included. Excludes access payments.)**

Age Gender		Medical PMPM Payment	Chiropractic PMPM Payment
Age 0	All	201.94	0.04
Ages 1-5	All	48.27	0.03
Ages 6-14	All	39.83	0.08
Ages 15-20	Female	77.99	0.13
Ages 15-20	Male	56.21	0.10
Ages 21-34	Female	151.26	0.28
Ages 21-34	Male	100.45	0.28
Ages 35-44	Female	207.43	0.41
Ages 35-44	Male	149.94	0.32
Ages 45 & Over	Female	240.82	0.44
Ages 45 & Over	Male	200.42	0.34

**CY 2010 Region 5 Benchmark Plan Medical Only Maternity Kick Payment
(No administrative allowance included. Excludes access payments.)**

	Medical PMPM Payment
All Ages	3,659.71

The specific methodology used by the Department to determine the medical costs for CY 2009 is included in Appendix E-2. The methodology specific to CY 2010 medical costs will be forthcoming. For CY 2011 and future years, the Department will set the medical cost PMPM rate on an annual basis to reflect the projected medical costs for the upcoming year.

Administrative Rate

CMS regulations allow administrative costs directly related to the provision of the Medicaid State Plan approved services to be incorporated in the rate-setting process. The administrative PMPM rate represents all the non-medical costs associated with administering the BadgerCare Plus Contract (Appendix A to this RFP), including maternity services. As part of this RFP, the Proposer must submit a Cost Proposal for the administrative PMPM rate at an amount that ensures the Proposer has sufficient resources to fulfill the duties of the BadgerCare Plus Contract (Appendix A to this RFP).

Member Chronicity

The Department adjusts the BadgerCare Plus Standard plan base capitation rates for member chronicity by applying the HMO's Chronic Illness and Disability Payment System (CDPS) score

to the rate. By doing such, the base rate is adjusted for each HMO's anticipated medical acuity. The Department uses CDPS with national concurrent weights. Since the BadgerCare Benchmark plan started in CY08, the Department will not be adjusting benchmark plan rates for chronicity in CY 2010. Benchmark Plan rates will be adjusted for chronicity starting in CY 2011.

For CY 2010, capitation payment will be adjusted retrospectively for chronicity. For CY 2011 and future years, the capitation payments will be adjusted annually to reflect the chronicity of the HMO's-specific population within the region. HMOs chronicity scores are set on an annual calendar year basis. The Department does not change the HMO specific CDPS score during the year.

Access Payments

The Department also adds to the base capitation rates payment amounts related to provider assessments such as monthly hospital inpatient and outpatient, and ambulatory surgical center access payments. The Department's monthly access payments to the HMOs are made as prospective PMPM payments, unadjusted for CDPS scores. For more information on access payments, see Art. VI, J and K in the BadgerCare Plus Contract (Appendix A to this RFP).

Quality Performance Penalties

Beginning in CY 2011, 3.25% of the HMO-specific capitation rate (excluding access payments) will be held at-risk annually based on the HMO's performance in meeting the Department's quality performance benchmarks detailed in Addendum VI in the BadgerCare Plus Contract (Appendix A to this RFP). Although the full HMO-specific capitation rate will be determined, 3.25% of that rate will not be paid out to the HMOs annually unless an HMO meets the Department's quality performance criteria.

8.4 Fixed Price Period

All prices, costs, and conditions outlined in the Proposal shall remain fixed and valid for acceptance for six (6) months starting on the due date for Proposals.

SECTION 9: SPECIAL CONTRACT TERMS AND CONDITIONS

9.1 Prime Contractor and Minority Business Subcontractors

The prime contractor will be responsible for contract performance when subcontractors are used. However, when subcontractors are used, they must abide by all terms and conditions of the contract. If subcontractors are to be used, the Proposer must clearly explain their participation.

The State of Wisconsin is committed to the promotion of minority business in the state's purchasing program and a goal of placing 5% of its total purchasing dollars with certified minority businesses. Authority for this program is found in ss. 15.107(2), 16.75(4), 16.75(5) and 560.036(2), Wisconsin Statutes. The contracting agency is committed to the promotion of minority business in the state's purchasing program.

The State of Wisconsin policy provides that minority-owned business enterprises certified by the Wisconsin Department of Commerce, Bureau of Minority Business Development should have the maximum opportunity to participate in the performance of its contracts. The supplier/contractor is strongly urged to use due diligence to further this policy by awarding subcontracts to minority-owned business enterprises or by using such enterprises to provide goods and services incidental to this agreement, with a goal of awarding at least 5% of the contract price to such enterprises.

The supplier/contractor shall furnish appropriate quarterly information about its effort to achieve this goal, including the identities of such enterprises certified by the Wisconsin Department of Commerce and their contract amount.

A listing of certified minority businesses, as well as the services and commodities they provide, is available from the Department of Administration, Office of the Minority Business Program, 608/267-7806. The listing is published on the Internet at:

<http://www.doa.state.wi.us/dsas/mbe/index.asp>.

9.2 Executed Contract to Constitute Entire Agreement

In the event of contract award, the contents of this RFP (including all attachments), RFP addenda and revisions, and the Proposal of the successful Proposer, and additional terms agreed to, in writing, by the agency and the contractor shall become part of the contract. Failure of the successful Proposer to accept these as a contractual agreement may result in a cancellation of award.

The priority for contract documents will be negotiated and defined in the contracts ensuing from this RFP.

SECTION 10: STANDARD TERMS AND CONDITIONS

The State of Wisconsin reserves the right to incorporate standard State contract provisions into any contract negotiated with any Proposal submitted responding to this RFP (Standard Terms and Conditions (DOA-3054) and Supplemental Standard Terms and Conditions for Procurements for Services (DOA-3681). Failure of the successful Proposer to accept these obligations in a contractual agreement may result in cancellation of the award.

These documents are posted with this RFP as separate attachments.

SECTION 11: REQUIRED FORMS

The following forms must be completed and submitted with the Proposal. Blank forms for this purpose are posted with this RFP as separate attachments. Proposers should attach supplemental pages to these forms as necessary.

Designation of Confidential and Proprietary Information (DOA-3027)
Vendor Information (DOA-3477)
Vendor Reference (DOA-3478)

APPENDICES

- A..... Contractfor BadgerCare Plus HMO Services 2010-2013
- B.....Cost Proposal
- C.....BadgerCare Plus HMO Certification Packet and Data Certification Requirements
- D.....Provider Facility and Urgent Care Clinic Network Submission Requirements
- E-1.....Rate Development Overview and Data Exhibits
- E-2.....BadgerCare Plus CY09 Capitation Rate Report
- F.....Maximum Enrollment Level