STATE OF CONNECTICUT
OFFICE OF THE HEALTHCARE ADVOCATE
STATE INNOVATION MODEL PROGRAM MANAGEMENT OFFICE

REQUEST FOR PROPOSAL (RFP) FOR
HEALTH ENHANCEMENT COMMUNITY CONSULTANT

SECOND Addendum

RELEASE DATE – 11-22-2017

The SIM PMO's official responses to questions submitted as of 4pm, November 22, 2017 are as follows:

1. **Question: We appreciate the State's flexibility and interest in Respondents' ideas on how best to structure activities to meet your objectives. Given the significant level of effort required to complete these activities, would the State have any flexibility in the available budget? Or any activities that can be deferred?**

   Response: The funding level established for this procurement is the maximum currently allotted to meet the five objectives. If, as a result of this solicitation the maximum allotted funding appears to be insufficient, the State may reduce the scope of individual objectives, in order to remain within the current allotment. *The State may also have the ability to seek additional funds if needed to achieve the overall goals of the initiatives*.

   Bidders may submit a proposal that is responsive to a subset of the objectives. Moreover, a bidder may also propose to reduce the scope of any given objective, e.g., in an effort to make best us of available resources or to better align with the bidder's capabilities.

   Whatever scope the bidder proposes, the bidder may propose a corresponding budget up to the maximum award. In doing so, the bidder should recognize that the bidder *may* be at a disadvantage in the selection process if the State does not otherwise have the resources to achieve such objectives.

   Preference will be given to proposals that will enable the State to fully realize all of the objectives with a single point of accountability, in accordance with the timetable, and within the maximum award. That said, *the State recognizes that all of the objectives may not be in their entirety and at an acceptable level of quality within the allotted budget*. The State reserves the right to select one or more bidders for negotiation based on the best interests of the State, bearing in mind the overall goals of this initiative.

   Finally, bidders may, at their discretion, include a two-page Proposal Supplement that briefly describes how their proposal would be revised if additional funds were available. Such Proposal Supplement will be excluded from the page limits otherwise established in *Section 5: Application Details*.

2. **Question: Given past experience addressing similar scopes of work, the budget outlined does not appear sufficient to support the extensive scope outlined in the RFP. Would the state consider alternative options for resourcing the stakeholder engagement (objective #2) and governance (objective #4) workstreams, through State staff or other contractors, in order to conserve the proposed budget for the more technical portions of the RFP (objectives #1 and #3)?**

   Response:

   See response to question #1 above.

   The objectives of this procurement are interdependent. Stakeholder engagement (#2) and the participation of SIM governance committees (#4) are indispensable for developing an HEC strategy (#1).

   While the state welcomes proposals from a single bidder responding to a subset of the objectives or a reduction in the scope of the objectives, its selection may depend in part on the State's ability to otherwise meet these elements of the scope.

   The State would further note that the *engagement of reference communities in Objective #2, Task 3, is a critical input to the achievement of Objective #1*. As such, this would not appear to be a task that can be undertaken separately, or by a different entity, without compromising the quality of the resulting plan.

3. **Question: Will the PMO and/or DPH provide the selected consultant with the Medicare data required to complete Objective 3? What is the anticipated timeframe for how quickly this data can be provided?**

   Response: The resultant Contractor will have access to the Medicare data via the All Payer Claims Database. We anticipate that we will be able to add the resultant Contractor's staff to the existing DUA soon after the Contract is signed. The APCD will be able to provide de-identified normalized data within approximately one week of our submitting the request.

   A longer timeframe may be required if the Contractor requires a limited Medicare dataset or an identifiable Medicare dataset. The bidder should indicate its requirements in its response.

4. **Question: Will the State consider a proposal exclusively for objectives #1 and #3 (including participation in but not staff support for stakeholder engagement and HISC/PHC meetings)?**

   Response: The State would consider a proposal exclusively for objectives #1 and #3, although as noted in the response to question #2 above, the State would prefer a proposal that also integrates the engagement of reference communities as envisioned in Objective #2, Task 3.

   Bidders should note, however, that the Population Health Council is the primary advisory body with respect to the entire initiative, particularly the strategy that emerges with respect to Objective 1. The State currently provides staff support for the Population Health Council, including the following:

   a) Maintaining adequate membership

   b) Scheduling meetings

c) Posting agenda and materials

d) Notifying the Secretary of States' office of scheduled meetings

e) Preparing and disseminating meeting summaries/minutes

f) Establishing meeting locations and arranging for remote participation

g) Other meeting logistics required.

The Contractor selected as a result of this RFP must be able to support the Council in its advisory capacity with respect to the objectives that fall within its scope. This support includes, but may not be limited to, the development of slide decks and related materials that educate, inform, and frame questions and options for discussion. A member of the Contractor's staff will be expected to facilitate the advisory and decision-making process as it pertains to the objectives that fall within the Contractor's scope. The Contractor must ensure that the Council's input is obtained throughout the process and that the final recommendations reflect this input. The State will rely on the Contractor for most of the Council meeting content during this intensive planning period.

5. **Question: In what format and over what timeframe will the State provide APCD data to complete analyses listed in Objective 1 and Objective 3?**

Response: The State plans to provide de-identified normalized data. The data dictionary for the normalized data can be found in the link below:

http://agency.accesshealthct.com/wp-content/uploads/2017/08/DRAFT-CT-APCD-Data-Dictionary-20170809.pdf

If the bidder has other or different requirements with respect to the Medicare data, the bidder should indicate such in its response.

Data available includes the following:

File	Years(s)	System of Record
CT state segment with 5% sample:		
MBSF (Base), IP, OP, SNF, Home Health	2012-2017	
(annual 2016 & quarterly 2017)		
Hospice, Carrier, DME	2012-2017	
(annual 2016 & quarterly 2017)		
PDE, Drug/Plan Characteristics, Formulary File	2012-2015	
(annual only)		
BENE_ID to SSN Crosswalk	2017	
BENE_ID to HIC Crosswalk	2017	
EDB User View	2017	

6. **<u>Question</u>: What progress has been made to date in strategy definition for HEC? Are there leading hypotheses for process/outcome measures, preferred financing approach, and financing root cause solutions?**

   <u>Response</u>: Planning for HEC has not begun. Accordingly, there is no additional information to share at this time with respect to strategy definition beyond what has been provided in the RFP. The State is considering whether the HEC strategy might be supported by a Medicare demonstration, potentially as a complement to second generation multi-payer payment reforms.

7. **<u>Question</u>: Can the State clarify the project timeline? Specifically, if Objectives 1 and 3 are to be completed by May 1, 2018?**

   <u>Response</u>: The State timetable currently contained in the RFP is a "best case" timetable that anticipates the completion of Objectives 1 and 3 in early May. However, the State will accept proposals based on an extended timetable, *preferably* one that would enable the completion of the entirety of the scope by September 2018 (see below).

EXHIBIT 1 (Extended): KEY OUTPUTS AND TIMELINE GRID

Key Outputs	Timeline
Guidance and subject matter expertise regarding HEC design and operational strategy provided	Ongoing
Population Health Council meeting facilitation	Monthly through contract end date
Periodic presentations to the Healthcare Innovation Steering Committee provided	Bi-monthly
Description of communication and stakeholder Engagement Strategy complete	First 30 days
Multi-sector stakeholders engaged	Contract start - ongoing
Synthesize the Connecticut-specific problems being solved and what success looks like	By 3/31/18
Recommend the role of key sectors in enabling HECs to succeed	By 3/31/18
Recommend community-wide measures and methods	By 4/30/18
Review existing value-based payment models and recommend adjustments	By 4/30/18
Recommend health information technology enablers	By 5/31/18
Recommend levers regarding workforce	By 5/31/18
Recommend financial models	By 6/30/18
Recommend statutory and regulatory levers	By 6/30/18
Conclude financial modeling using Medicare data	By 6/30/18
Partial Draft 1 of report detailing the HEC initiative strategy	By 7/09/18

Conclude analyses with respect to other state agency service expenditures to which health improvement benefits would likely accrue	By 7/16/18
Conclude work with 2-3 employers to model the potential value of prevention efforts	By 7/16/18
Produce a flexible financial modeling tool using Medicare data	By 7/16/18
Final draft of report detailing the HEC initiative strategy	By 7/23/18
Final Draft of report disseminated to Healthcare Innovation Steering Committee	By 7/30/18
Presentation to Healthcare Innovation Steering Committee – Review and discussion	By 8/09/18
Release HEC Report and Recommendations for public comment	By 8/12/18
Presentation to Healthcare Innovation Steering Committee – Final Review and Approval	By 9/13/18