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

REQUEST FOR PROPOSAL (RFP) FOR CONSULTATION SERVICES

THIRD Addendum

RELEASE DATE – 082814

The SIM PMO's official responses to questions submitted as of 3 p.m., August 28, 2014 are provided below. This is our final response to questions. Please note that we are in the midst of a more detailed design and development phase. For this reason, a number of our responses may not provide the level of specificity requested.

1. "Big Data" and Data Science/Analysis: Are there data science/analysis initiatives involved that might impact success and thus be a priority for the PMO?

   Response: Most of more relevant data analytic initiatives are highlighted in our Connecticut Healthcare Innovation Plan (December 30, 2014), which is available at http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2741&q=335318. Note that responsibility for health information exchange rests with the Department of Social Services as of 7/1/14.

2. CAB and Steering Committee: We are hypothesizing that one senior member of the PMO might need to devote a significant amount of time engaging and optimizing the Consumer Advisory Board (CAB) and the Steering Committee. Is our hypothesis is sound?

   Response: We anticipate contracting with a program coordinator to support consumer engagement in collaboration with the CAB in late fall 2014.

3. Cloud Computing and Shared Technology Infrastructure: One of our clients is in the process of installing a shared IT infrastructure. There is a long lead time requirement to reduce costs (harvest funding) and allow sharing information for seventeen (17) independent federal agencies – with global reach. Will there be a similar challenge for SIM and the PMO?

   Response: We cannot comment based on the information provided.

4. Community Colleges: How are things progressing with the Community Colleges referenced? How can the PMO help?

   Response: The PMO will support the Workforce Council, which will be the primary vehicle for engaging Connecticut's community colleges.

5. CT Institute for Primary Care: How are things progressing, and what are the lessons learned related to establishing the CT Institute for Primary Care?

   Response: Current information regarding the Connecticut Institute for Primary Care Innovation is available at http://www.cipci.org/.

6. Culture Alignment: To what extent will culture alignment be a challenge as the critical stakeholders begin to collaborate and work together to improve care delivery and cost effectiveness?

Response: The SIM initiative does involve continuous work with stakeholders to align expectations and bridge the different priorities and interests that drive each of our major stakeholder groups.

7. Data & Analytic Tools: How mature and effective are the "data and analytic" tools (needed) to drive "transformational change" referenced on page 16 of the Grant Application dated July 16, 2014?

   Response: The maturity and effectiveness of the data and analytic tools varies considerably amongst the various payers and providers.

8. DSS: Pages 15 and 16 of the of the Grant Application dated July 16, 2014 highlight PMO and DSS responsibilities. How prepared is DSS for partnering, and are the shared roles and accountabilities clear to all concerned?

   Response: DSS is well prepared to partner with the SIM PMO. Roles will be further clarified during the next few months of planning. A Memorandum of Agreement will be negotiated as it pertains to SIM funded activities that will be carried out by DSS.

9. Exemplars: Are there other states you see as exemplars in terms of their progress and effectiveness where we can leverage their lessons learned?

   Response: Each of the six states awarded SIM test grant funds in the first round serves as a point of reference for our efforts in Connecticut.

10. FQHC Support: What funding, governance, and implementation protocols and processes exist for the PMO to support FQHC's and "enter into SSP contracts"? Does the PMO have funds and contracting authority?

    Response: DSS will be administering the Medicaid Quality Improvement and Shared Savings Program (QISSP) including any corresponding contracts with FQHCs. We anticipate that detailed implementation plans will be prepared by DSS by January 2015.

11. Governance and Authorities: Have you had the opportunity to consider the authorities and the approach to governance that will help enable the PMO to:
    - approve and possibly refine and align detailed action plans developed by others and
    - guide and possibly redirect groups and individuals that are off-plan or struggling?

    Response: The SIM PMO convenes a core team comprised primarily of state agency partners. The SIM PMO will work with this team and the successful Respondent to update and monitor the program plan. The team will maintain a list of issues that require resolution and address delays as they occur.

12. Governance: If the Healthcare Innovation Steering Committee is chartered as "advisory" - in terms of overall SIM's governance, who is accountable for accepting advice then making decisions – including disbursing funds, approving work accomplished, and modifying schedules, staffing, and goals?

    Response: The ultimate authority for the State Innovation Model Initiative rests with the Office of the Lieutenant Governor. The SIM PMO has the authority to make most of the administrative decisions required for day to day management of the program.

13. Health Plans: What should our expectations be regarding the level of staffing, accountability, and the skills involved for the participating health plans?

Response: You should expect that the health plans will commit necessary and appropriate resources commensurate with their role in this statewide initiative.

14. Healthcare Workforce Training: Do healthcare workforce training protocols and curriculum exist? Is there testing and certification involved? How can the PMO help?

    Response: Yes protocols and curricula exist today. The question regarding certification and testing depends on the professional classification. In the case of community health workers, there is not currently a state certification.

15. HIT Assets: How mature, effective, and scalable are the assets highlighted on page 17 of the Grant Application dated July 16, 2014?

    Response: This information is not readily available.

16. Implementation Obstacles: To what extent will the implementation plans be influenced by cash flow and pending legislation?

    Response: An insurance assessment was established in the SFY14 legislative session to fund the SIM PMO. We do not anticipate cash flow issues. No legislation is pending.

17. Information/Data Security: Are information/data sharing and security a concern during and following full implementation?

    Response: Information/data sharing and security will be a consideration in all aspects of health information technology planning.

18. IPE Training: How has planning and implementation progressed with IPE training and the "Area Health Education Center". How can the PMO help?

    Response: Please see Issue Brief #6 at http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2765&q=335344 for additional information about IPE Training (i.e., CT Service Track). The PMO will support the Workforce Council, which will be the primary vehicle for overseeing IPE activities funded under SIM.

19. Laws and Regulations: Will laws and regulations need to be modified, created, or discontinued? If so, is the process manageable or of concern to the PMO?

    Response: At this time, the SIM PMO does not anticipate the need for new legislation. The state will assess the need for regulatory changes during the next phase of planning.

20. Legal Decisions: Is it anticipated that legal opinions will be a factor. If so, can we rely on the State's legal staff?

    Response: We may from time to time require legal opinions. We will typically rely on state agency counsel or the Attorney General's office for such opinions.

21. Lessons Learned: What are the most important lessons learned by the SIM team to date? Will it be valuable to leverage them going forward?

    Responses: The only available summary of lessons learned was produced for our final report to CMMI regarding our Model Design Grant. An excerpt of this report is provided in a Supplement at the end of this addendum. Note that some elements of this summary of lessons learned have been super-ceded by events over the past few months in the course of preparing Connecticut's SIM Test Grant application.

22. Participation Projections: What are the planning assumptions involved in the predictions? How can the PMO facilitate participation?

    Response: Our projections assume that the Medicaid QISSP RFP process will attract a substantial number of Advanced Network and FQHC applicants, based on interest expressed during the Model Test application development process. Beneficiary projections are estimates based on the anticipated number of successful provider applicants and their attributed beneficiaries.

23. Physician Transition: We understand there are an estimated 21K physicians in Connecticut, with approximately 3.3K in primary care. If those numbers are approximately correct, how do you see primary care physicians transitioning to AMH? What will drive them there?

    Response: The number of active physicians in CT as of this response is 17,461. We believe that Advanced Networks will be interested in enrolling their unrecognized practices in the AMH Glide Path program to help defray the cost of transformation.

    We are in the process of administering a physician survey to gauge the interest of CT independent primary care physicians. We believe that many independent primary care physicians will be interested in improving their performance and keeping pace with their peers and will see the AMH Glide Path program as a cost-effective means to do so.

24. PMO and SIM – Mandate, Accountability, Staffing & Skills, Budget, and Authorities: What decisions have been made about SIM overall and the PMO related to mandates, accountabilities, personnel staffing and skills, budgets, and authorities?

    Response: The most up-to-date summary of our program design and staffing structure is contained in our SIM Model Test Grant application, which is available at: http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2741&q=335460. The application reflects key decisions made subsequent to the submission of the Connecticut Healthcare Innovation Plan in December, 2013.

25. Primary Care Process: Page 3 of the Grant Application dated July 16, 2014 includes the phrase "…requires redesigned primary care processes." Could you provide additional details on the desired process, its major elements. and the implementation timeline, benefits, risks, and risk mitigation options? What managerial role do you envision for the PMO in addressing SIM's objectives in the redesigned process? Will Connecticut be a pioneer, or is the process envisioned in place in the U.S. today?

    Response: Please see our SIM Model Test Grant application, which is available at: http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2741&q=335460. In general, the SIM PMO will manage elements of the SIM initiative that are beyond the scope of existing line agencies, and it will assume a coordinating role as it pertains to elements that transcend or lie outside the scope of existing line agencies.

    Many states are undertaking broad-based multi-payer reform initiatives. Connecticut's plan is distinct with respect to the high degree of multi-payer participation (including employers); its focus on health equity and care experience; its emphasis on Value-based Insurance Design; and its effort to establish safeguards against under-service.

26. Regional Network: How can the PMO be most effective engaging and partnering with the regional network in place today and into the future?

    Response: This question is not clear.

27. Risk Management: What do you see to be the most significant risks, mitigation plans, and risk management processes and reporting?

    Response: Risks and plans for mitigation are identified in the Operational Plan of our SIM Model Test Grant application, which is available at: http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2741&q=335460.

28. SIM's Roadmap, Milestones, and Resources: It would be helpful for our PMO planning to better understand the people, their time, and talent that will be available and the roles and accountabilities planned – at least for the immediate future.

    Response: Personnel and roles are identified in the Budget Narrative of our SIM Model Test Grant application, which is available at: http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2741&q=335460.

29. Synergy: Given the complex objectives and time commitments of the people involved with SIM, and their parent organizations, what challenges related to talent availability are likely to surface or perhaps have to date?

    Response: Developing a strong and capable team within state agencies and a new office such as the SIM PMO is an ongoing effort. Contracted partners such as the State is pursuing through this RFP should enable us to address temporary or ongoing gaps in our team and capabilities.

30. System-wide Performance Metrics: What improvements, in what performance metrics, are expected – year over year, as you reach your five year targets?

    Response: Projected improvements in system-wide metrics are provided in the Evaluation section of our SIM Model Test Grant application, which is available at: http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2741&q=335460.

31. Talent – All Stakeholders: We understand from your very helpful websites that many people have been involved in SIM for months. If we are selected, how and when can we partner with them to be certain we can leverage their insights, perspectives, and lessons learned?

    Response: The primary means for engaging with our stakeholders is through the various entities that comprise the Governance Structure, as described in this solicitation. Secondarily, the SIM PMO could arrange meetings with stakeholder groups as needed to support program implementation or the continued development of our stakeholder engagement strategy. Such meetings could occur shortly after Contract execution.

32. Teaching Health Center Grant: What are the prospects for funding awards through a Teaching Health Center grant from the "Health Resources and Services Administration"?

    Response: Please see Issue Brief #7 at http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2765&q=335344 for additional information about Teaching Health Centers.

33. VBID: With respect to Value Based Insurance Design (VBID) adoption efforts – is there a PMO role model for guiding the PMO's execution of the approximately nine (9) activities highlighted on page 12 of the Grant Application dated July 16, 2014?

    Response: Please see Issue Brief #5 at http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2765&q=335344 for additional information about our Value-based Insurance Design plan.

34. PMO: Computer Applications Development, Maintenance, or Retirement: To what extent will computer applications be a factor in achieving success?

    Response: This question is not clear.

35. Consumer Engagement: What PMO competence and level of effort is contemplated to support Consumer Engagement and when, and for how long, will that support be needed?

    Response: We are planning to dedicate a single program coordinator to support consumer engagement in collaboration with the Consumer Advisory Board in late fall 2014 and to maintain that position ongoing. Additional resources for consumer engagement are listed in the budget narrative on page 11.

36. Continuity: Which SIM team members involved to date will be continuing, in what roles, and what percent of their time, weekly – overtime? Can they partner with the PMO?

    Response: The Director of Healthcare Innovation and administrative assistant are continuing. The PMO hiring is proceeding with the expectation that those positions identified in our SIM Model Test Grant application will be filled by March 2015. State agencies have designated leads who will continue to play an active role in design and implementation, including participation in our various work groups. These state agencies include the departments of Social Services, Public Health, Mental Health and Addiction Services, and Children and Families, as well as the Office of the State Comptroller and Access Health Connecticut.

37. Council and Task Force Staffing: When you consider the four councils and one task force highlighted on page 5 of the RFP - is that enough help and do they adequately represent all critical stakeholders to ensure adequate input and sense of ownership? How comfortable are you in terms of their:
    - staffing - #'s, availability, commitment, and skills and
    - alignment with your goals and oversight's expectations?

    Response: At this time, we believe that the proposed governance structure is sufficient, with the addition of the designated committee for planning the Medicaid QISSP established under the Medical Assistance Program Oversight Council (MAPOC). We believe that sufficient stakeholders are included in the proposed work group composition or will be included through the creation of ad hoc design groups to address special issues (e.g., behavioral health integration).

38. Funding and Cash Flow: How significant a challenge is funding and cash flow to fund the people, technology, and change initiatives, and how can the PMO be helpful?

    Response: Each proposed element of our SIM initiative presents special funding challenges, which will need to be addressed on an ongoing basis through a combination of state, federal and private funds.

39. Governance and Time Management: Our most demanding PMO engagements have often involved daily and weekly reviews of progress and challenges with the goal of quickly identifying and mitigating obstacles. What approach to governance and time management seems best for SIM?

    Response: We anticipate weekly progress reviews and resolution of issues to include PMO staff, state agency leads, and the successful Respondent to this solicitation.

40. Immediate Start-up: Have you yet planned the daily actions you desire of the PMO to ensure everyone is aligned and focused on the same milestones? How comfortable are you that the SIM team members understand their roles and have the necessary skills and time?

Response: We have not planned all of the daily actions. We have charters, meeting schedules and a timeframe for the production of deliverables for three of our five workgroups. We are in the process of plan development for other elements of our program.

41. Oversight: What Federal or Connecticut oversight authorities are, or should be, involved?

    Response: The SIM initiative is broad in scope and includes initiatives that fall within the scope of all of the state agencies and offices represented on the Healthcare Innovation Steering Committee (see www.healthreform.ct.gov for member listing), in addition to the Office of the Attorney General. Federal authorities include CMS for Medicare and Medicaid and HRSA for workforce and FQHCs.

42. In terms of transitioning the PMO to CT state employees – how soon is that likely and how can, or should, the PMO help expedite the process?

    Response: PMO staffing is currently comprised of state employees, which will be supplemented by consultative support obtained in part through this solicitation. Additional state employee hiring is proceeding with the expectation that those positions identified in our SIM Model Test Grant application will be filled by March 2015.

43. PMO Deliverables and Meetings: Are there important deliverables or meetings scheduled within the next 60 days?

    Response: Important meetings are posted at www.healthreform.ct.gov. There are no identified major deliverables that the successful Respondent will be expected to complete within the next 60 days.

44. PMO Exemplars: Are there exemplary "SIM-like" PMOs operating in Connecticut or in other states, that you respect, that can serve as exemplars in terms of PMO talent, experience, processes, protocols, culture, technology, and other resources?

    Response: We have no information about such exemplary PMOs.

45. PMO Planning: What planning assumptions were involved in developing the $3.2 million annual assessment for PMO support? Do the CT health plans have specific expectations of the PMO that we should consider in PMO staffing?

    Response: Our budget assumed that process for hiring PMO staff would occur over an extended period to be concluded in 2015. It also assumed that a substantial portion of proposed SIM activities would be funded through federal grant support. It further assumed that other activities would occur regardless of federal grant support including, but not limited to, stakeholder engagement, evaluation, physician survey, modification of the on-line MD license renewal process to support data collection and analysis, consultation support for the administration of work groups, and limited primary care transformation services.

46. PMO Space and Technology Infrastructure: How do you visualize the PMO in terms of:
    - talent and space – skills, headcount (FT/PT) and where would you like them located in terms of meeting rooms and A/V and
    - computers and compatible software and databases required?

    Response: See response to Question 4, First Addendum.

47. Stakeholder Engagement: In terms of engaging stakeholders – Is there an accurate list of names and contacts?

Response: A complete list of stakeholder participants in our governance structure is available at www.healthreform.ct.gov. Contact information will be provided to the successful Respondent when appropriate.

48. State Employees: How has the PMO been conceptualized in terms of staffing, skills, governance, and authorities over-time? When is it most likely state employees will start - with what skills and authorities?

    Response: The most up-to-date summary of our program design and staffing structure is contained in our SIM Model Test Grant application (especially Budget Narrative and Operational Plan), which is available at: http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2741&q=335460. PMO hiring is proceeding with the expectation that those positions identified in our SIM Model Test Grant application will be filled by March 2015.

49. Technology Tools: Many software tools are available to help enable effective program management and to communicate progress, challenges, and status. Have those tools and the enabling data processing and display systems been acquired and perhaps used during the planning activities? Do you feel strongly about the best technology tools for SIM?

    Response: The PMO relies on the Microsoft Office suite of software tools. More specialized software tools to help enable effective program management and to communicate progress, challenges, and status have not been acquired.

50. Workgroups: What level of participation is needed and expected related to the workgroups; design and implementation activities? Who is accountable? How will their policy, process, and governance design be approved as feasible, affordable, scalable, and consistent with SIM's goals and commitments?

    Response: The PMO is accountable for ensuring that the work groups produce planned deliverables. We do not have a response at this time to other elements of this question, but will discuss these issues with the successful Respondent.

51. Contracting Authority: How will the PMO contract with vendors and have they been selected? For how long? Does the PMO have contracting authority and funding?

    Response: The SIM PMO does not currently have a private sector contracted team. The SIM PMO does have a relationship with the University of Connecticut and University of Connecticut Health Center related to the evaluation and facilitation of the Practice Transformation Taskforce. Vendors will be selected and contracted in accordance with the State of Connecticut's procurement and contracting standards. The PMO has contracting authority and funding to support the activities identified in our response to Question 45 above.

52. Consulting Resources: Are there caps on our consultants staffing levels, hourly rates, or daily and monthly work hours?

    Response: Caps or limits will be subject to negotiation in the Contract resulting from this procurement.

53. Invoicing: In terms of invoices – Who will be approving them? What is the approval criteria and what is your goal in terms of payment timing?

    Response: The Director of Healthcare Innovation will initially be responsible for approving invoices. Criteria for payment and timing will be specified in the Contract that results from this procurement.

54. Consulting Colleagues: Are there other consultants involved we can assist, or who can assist us – as a collaborative team?

    Response: See response to Question 51 above.

55. Has a "consultant's roundtable" been considered to at least meet initially - to learn from the professionals who developed the extensive planning materials made available to us?

    Response: A consultant's roundtable has not been considered. Since January, most of the planning has been undertaken by professionals and other stakeholders who continued to be involved with this program today.

56. Leveraging Lessons Learned: Who can we partner with immediately to be certain we understand the history and lessons learned?

    Response: We recommend that the successful Respondent meet with the PMO staff to discuss history and lessons learned and consider with the PMO whether interviews of this type with selected state agency officials and stakeholders would be of value.

57. PMO Consulting Talent: Our most complex PMO engagements have demanded intensely-focused and engaged consulting talent with significant experience. In most complex PMO engagements, we focus on having the most-senior consultants onsite on, or before, Day 1 – We then begin to draw appropriately experienced support or subject matter experts (SMEs) as they are needed and we are clear about the space and technology support, their roles, skills, deliverables, and timelines. What is your version? How do you see the level of PMO experience and onsite engagement essential for SIM's sustainable success?

    Response: We are seeking focused and engaged consulting talent who would bring subject matter expertise or draw upon such expertise as it is needed. The work would begin immediately upon execution of the contract and authorization by the Attorney General's office.

58. The RFP states, "The Respondent's submission must include a Statement of Acceptance, embedded as a hyperlink, Procurement Agreement Signatory Acceptance (Appendix B), without qualification of all terms and conditions within this RFP and the Mandatory Terms and Conditions, embedded as a hyperlink, mandatory terms and conditions (Appendix A), for a PSA contract. The Respondent may, however, suggest alternative language to the Mandatory Terms and Conditions." Can you please clarify this requirement? What specifically must be embedded as a hyperlink in the response?

    Response: The references to the embedded hyperlinks is to the hyperlinks embedded in the solicitation itself, where underlined above. Note that the second hyperlink to "mandatory terms and conditions" was incorrect. The correct hyperlink is contained in the response to Question 76 in this addendum.

59. May the Respondent also suggest alternative language to the "Other Conditions" listed in Attachment A in the RFP?

    Response: The "Other Conditions" are the same as the "Mandatory Terms and Conditions." Per the language on page 11, "The Respondent may, however, suggest alternative language to the Mandatory Terms and Conditions. The PMO may, after consultation with the Office of the Attorney General and the Office of Policy and Management, agree to incorporate the alternate language in any resultant contract; however the PMO's decision is final."

60. Can you clarify the number of hours that the Respondent is expected to be on-site each week?

Response: An on-site presence is preferred and the Respondent's capacity to support on-site should be described in its response, however, there is no specific requirement.

61. Are all team members expected to be on-site every day, or is it sufficient to have one or two team members on-site, and the remainder of the team working at a remote office location?

    Response: There is no minimum requirement.

62. If the Respondent has held multiple contracts with the state of CT, do you require every one of those projects to be listed as a reference, in addition to other non-CT references?

    Response: Yes.

    Questions 63 through 64 pertain to the following section of the RFP:

    On page 7 of the RFP, you state that the Respondent will be expected to support two of the five work groups with the potential to provide support to the other three work groups as requested. Then on page 8, you provide the number and frequency of the work group meetings. Our questions are as follows:

63. Do these frequencies pertain only to the Quality and Equity/Access Councils or do they pertain to each work group?

    Response: These assumptions may be applied to other work groups for the purpose of this solicitation.

64. In our cost proposal, should we only factor in work group meetings (scheduled and ad hoc) for the Quality and Equity/Access Councils or should we factor in any other work group meetings?

    Response: See response to Question 5, Second Addendum.

65. On page 21, Section 4 Evidence of Qualified Entity, is the written assurance required as part of the proposal we submit or as part of the contracting process after selection?

    Response: This is a requirement of the proposal.

66. On page 22, Section 7 Small, Minority or Women's Business Enterprise, is the Respondent required to set aside a portion of the contract for such a subcontractor (even if we have all the capabilities within our two firms) or simply required to make a good faith effort to use a qualified Small, Minority or Women's Business Enterprise in the event we need to subcontract a portion of the work?

    Response: The successful Respondent will be required to make a good faith effort to use a qualified Small, Minority or Women's Business Enterprise in the event that they need to subcontract a portion of the work.

67. Will the successful vendor for the SIM PMO services be precluded from additional RFPs or project work related to implementation of SIM projects should Connecticut be awarded a Testing grant?

    Response: The solicitation notes that "Bidding on and/or being awarded this contract shall not *automatically* preclude the Respondent from bidding on any future contracts related to the SIM" [emphasis added]. A determination as to whether the successful Respondent shall be qualified to bid will be informed in part by the relationship between the Respondent's final

negotiated scope and the scope of any new SIM related business opportunity that is undertaken by the PMO. The potential for such opportunities may be a consideration by either party in the negotiation of the Contract that results from this solicitation."

68. According to the RFP, "The resulting contract will be a Personal Service Agreement (PSA) contract between the successful Respondent and the PMO." Is there any price limit on a PSA?

    Response: See response to Question 27, Second Addendum.

69. How many stakeholder groups would the vendor be expected to interact with (i.e., state agencies, consumers and consumer advocates, health plans, employers, providers, etc.)?

    Response: The major stakeholder groups include the five identified above. Connecticut has three major employer groups involved in healthcare policy, approximately a dozen state agencies and offices doing work related to SIM, one health plan association, perhaps 10 to 20 major provider organizations, and an even larger number of consumer advocate organizations.

70. How many resources does the State currently have devoted to the project in the PMO?

    Response: The PMO has a budget of approximately $3.2 million for SFY15, in addition to approximately $1.9 million in bond funding to support health information technology projects.

71. The State references analyzing, evaluating, and interpreting data. What type and volume does the State anticipate needing assistance with?

    Response: This statement refers to data that might be available in publications and in the non-published gray literature (white papers, websites, etc.) and potentially could include data collected for example through stakeholder surveys, interviews, or a review of other programs. We anticipate that engagement in these activities would be modest. We are not at this time seeking a partner to undertake healthcare data analytics.

72. The RFP specifies the requirement to develop and implement communications and public relations strategies and methods potentially including presentations, website, learning collaborative portals, blogs, articles, branding/messaging, speaking events, conferences and media. In order to better estimate the level of effort; can the State clarify what tasks they would like included in the scope?

    Response: This specificity will be developed during the next phase of our planning process.

73. Would there be any meeting facilitation and support provided to groups outside of the governance structure on page 5?

    Response: The Respondent should assume that meeting facilitation and support may be provided to groups outside of the governance structure provided on page 5 of the solicitation.

74. Would the same level of support be anticipated for any additional groups the State identifies as needing support (6 meetings until January, and monthly meetings after that)?

    Response: This is a reasonable working assumption for the purpose of this solicitation.

75. Given that the deadline for written questions is 8/27/14, but the State indicated responses provided by 8/20/14, would the State be willing to provide an extension of the due date to allow for appropriate time to address the answers to questions in the response?

Response: The deadline for written questions was extended to 8/28/14 at 3pm per our response to Question 1, First Addendum. The State committed to and provided an initial response by 8/20/14 and weekly thereafter. Respondents are advised to raise substantive questions early in the process so that responses will be received well in advance of the proposal due date. The deadline for responses will not be extended.

76. On page 11 of the RFP, there are hyperlinks to documents. One such link is supposed to be to the Mandatory Terms and Conditions. However, that link is to "Procurement Standards: For Personal Service Agreements and Purchase of Service Contracts". Please provide the correct link or the document.

    Response: The correct link to the mandatory terms and conditions is http://www.ct.gov/opm/cwp/view.asp?a=2981&q=382982.

77. The RFP states, "THE RESPONDENT SHALL provide written assurance to the PMO from its legal counsel that it is qualified to conduct business in Connecticut and is not prohibited by its articles of incorporation, bylaws, or the law under which it is incorporated from performing the services required under any resultant contract." Does the answer to this item need to be signed by legal counsel, and/or presented on the letterhead of the legal counsel's office? Or is a statement that the respondent is qualified to conduct business in CT sufficient?

    Response: It is acceptable to include the statement in the Respondent's transmittal letter.

78. P8 , Sec 2. Website, portals, blogs. RFP addenda clarify that the state, not the respondent, will operate the website. Can you further clarify which of the following activities related to creating the website the respondent is expected to perform: (a) write content for publication on website (b) design website graphics, format, and user interface (c) design website business processes (eg user registration) (d) write code to create website based on design.

    Response: The Respondent may be asked to undertake any of the above noted activities. The Respondent should consider the current design and functionality of the website (based on the Respondent's review as it exists today) and the capabilities that the Respondent envisions may be needed to support advanced stakeholder engagement activities.

79. P19, Sec B(1)(A). Meeting facilitation. The RFP states that "Proposals should include a detailed work process." Elsewhere the RFP states that the respondent shall support the Quality Council and Equity and Access Council. RFP second addendum response #5 states that respondent should assume it will support a minimum of four work groups. Of the five work groups identified in the governance structure, are there four in particular for which respondent should describe a detailed work process?

    Response: The choice of four is at the Respondent's discretion.

80. P20, Sec 2C. Resumes. RFP requires "An identification of all state agency(s) in CT and all other states or commercial vendors with which it had a contract in the past 5 years." Does "commercial vendor" include any private corporation or does this refer only to vendors of a state government?

    Response: This refers to vendors of a state government. Although not a requirement, the Respondent may include other private sector contracts to the extent that such contracts are closely related to the proposed scope of work under this solicitation.

81. P20, Sec 2C. Resumes. RFP requires "An identification of all state agency(s) in CT and all other states or commercial vendors with which it had a contract in the past 5 years." Does "contract" refer to a contract between the individual listed on the resume and third parties (e.g., his employers) or to contracts between the Respondent and clients specific to projects

to which the individual listed in the resume was assigned? Put another way – if for each included resume, the respondent submits a list of the individual's employers and projects for the past five years, will that be considered responsive to this section?

Response: We are interested in the following:

- contracts that the Respondent had that meet the requirements noted in Question 80 and that involved the individual listed on the resume.
- contracts that a different organization or entity might have had that meet the requirements noted in Question 80, if the individual listed on the resume was working for that organization or entity and was assigned to the contract in question, and
- contracts that meet the requirements noted in Question 81, that the individual listed on the resume held directly.

82. P20, 3 References. Is the respondent expected to provide three references total or three references per resume?

    Response: The Respondent must provide no fewer than three references in total. We prefer that the Respondent provide additional references as necessary to support each of the members of the management team including subcontractors. This is especially important if the individual provided services to the State of Connecticut, whether working for the Respondent or otherwise.

83. Related Public Document. "State of Connecticut SIM Grant Request Response to Questions and Revised Budget Narrative, February 4, 2013" (http://www.healthreform.ct.gov/ohri/lib/ohri/sim/revised_model_design_app_docs/ct_sim_revised_budget_narrative_v1_02042013.pdf). Does this document reflect Connecticut's actual adopted budget for the described scope of work, or merely a proposed budget at a particular stage of the planning process? More specifically, on p8, Sec H1. Contractual Costs – Strategic Planning and Project Management: Does the data contained in this section describing hourly rates and total fees represent actual amounts paid by the State of Connecticut and/or agreed upon in a contract?

    Response: The above referenced document was produced as part of Connecticut's SIM Design Grant and bears no relation to the scope of this solicitation, which pertains to the SIM Test Grant. As noted earlier, our SIM Model Test Grant application (including a Budget Narrative) is available at: http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2741&q=335460.

84. How does the PMO envision engaging consumers more broadly in the stakeholder process?

    Response: Our SIM governance structure establishes formal mechanisms for on-going consumer engagement. The Consumer Advisory Board (CAB) is the primary facilitator for consumer engagement. The SIM PMO and the successful Respondent will work with the CAB to further detail its consumer engagement strategy.

    CAB members are deeply involved in a diverse group of community and advocacy organizations. The CAB supports consumer representation on SIM workgroups through cross-workgroup sessions, standing sub-committees, ad-hoc work groups, and communications for informed participation. For example, consumer representatives on the Quality Council will provide perspective on how consumers should be informed of cost and quality information so that they can choose high value providers, while those on the Equity and Access Council will participate in the development of methods to guard against under-service and denial of service, and those on the Practice Transformation Task Force will ensure whole-person-centered care lives up to the ideals and principles of the state's Innovation Plan. The CAB will also establish sub-committees that will focus on crosscutting issues such as population health, behavioral health, and health equity.

The CAB has proposed that the SIM PMO support consumer engagement that meaningfully integrates the consumer perspective and provides outreach and education for consumers about how innovation will change their experience of healthcare. Proposed programmatic activities include consumer-led learning collaboratives, issue-driven focus groups, and targeted communications. Consumer outreach will leverage the regional network established by the state's navigator and in-person assistor program, which enabled the state to double its enrollment goal in AccessHealthCT. Learning collaborative curricula will be designed to provide consumer education, serve as a forum for listening tours, and integrate consumer perspectives and healthcare experiences in feedback loops to the Steering Committee and workgroups.

85. Does each subcontractor also have to provide 3 references?

    Response: Please see response to Question 82.

86. What level/skill set and/or role(s) would you prefer to have from the person(s) co-located with the PMO?

    Response: We are not prepared to offer a preference at this time. Our preference will depend on the overall strategy, team and methods proposed by the Respondents.

87. When the two full-time durational project managers are hired, how will the need for consultant PMO project management support change?

    Response: We anticipate that we will continue to need consulting support for the work groups well into 2015, and in some cases, this support may be ongoing. Certain other functions such as project planning, a liaison role with Medicaid related to planning for the QISSP, oversight of practice transformation services, or stakeholder communications may be reduced as management is put into place, durational or otherwise. The timing and nature of any reduction will depend on the timing of our hiring and the role and capabilities of the staff that are hired.

88. To what extent is change leadership skills training needed/envisioned?

    Response: We do not anticipate a need for substantial change leadership training; however, we are prepared to be educated on this point.

89. Could you please identify the four work groups that will definitely require consultant support.

    Response: We are certain that we will require support for the Equity and Access Council and the Quality Council. We have not finalized whether additional support will be required for Health Information Technology, Workforce, Practice Transformation, or another work group that may be established outside of the governance structure depicted on page 5. We ask that Respondents base their proposal on four work groups, without knowing for certain the identity of two of the four.

SUPPLEMENT

Lessons Learned – Excerpt from the State's final report to CMMI regarding the Design Grant Process (March 2014)

LESSONS LEARNED

A) Time between the end of stakeholder feedback and production of the final version of the plan was limited.

Due to the intensive stakeholder engagement efforts which occurred close to the time of final submission, additional editorial resources were enlisted. Editing was broken into phases, with thorough problem solving sessions occurring periodically around unresolved issues. A tracking mechanism for outstanding issues was established and the team was able to address them all before submission, by either incorporating them in the plan or delineating who holds accountability for developing solutions during the detailed design phase. In the first quarter of 2014, a public document will be released with responses to major areas of concern.

B) Resources required for full implementation of comprehensive community improvement strategies greater than anticipated.

The State is currently evaluating options to ensure that our Prevention Service Center model is financially sustainable. During the initial pilot phase, the State will consider the possibility of securing start-up funding from Connecticut's health foundations, allocating a portion of the test grant funds on a time-limited basis, or encompassing these costs in advance payments. Beyond an initial one or two year start-up phase, the State anticipates that primary care providers will purchase such services as needed to achieve their quality objectives (e.g., reducing hospitalization rates for asthma). We do not intend to establish an exclusive market for Prevention Service Centers within any geographic area. Accordingly, the viability of a Prevention Service Center in the long run will depend on the value of the services that they provide to their primary care practice clients.

C) Consumer advocates felt that the strategies to inform and involve consumers and advocates in the initial governance structure of the design should be improved.

Two special meetings were convened with consumer advocates during October and November to solicit substantive input on the preliminary model and published Innovation Plan. These meetings also reviewed concerns about the extent of consumer and advocate participation in the governance structure for model design. As a result of this feedback, two consumer advocates were added to the Steering Committee as of November 2013. Plans for the future governance structure include the addition of consumer advocates and consumers to the planning councils and taskforce. Consumers are distinct from consumer advocates in that their sole credential is that they utilize healthcare services. We will be seeking more involvement of consumers, including individuals who represent Medicare, Medicaid and other perspectives on our planning councils and task force. A Consumer Advisory Board will be reconstituted early in 2014 to substantially enhance the voice of consumers and consumer advocates, and to support consumer involvement in the steering committee, planning councils and task force.

D) A number of physician providers, both primary and specialty care, and their respective associations felt that tort reform was essential to achieving the projected reductions in waste and cost under SIM.

Some physicians felt that they could not reasonably be held accountable for costs a portion of which they believe is a result of practicing defensive medicine, unless there were protections from malpractice lawsuits. They are concerned that there will be additional malpractice exposure as a result of reducing unnecessary tests and procedures. There was particular interest in "safe harbor" malpractice reforms, which would protect physicians from malpractice lawsuits if providers follow specific utilization and appropriateness of testing guidelines. Some physicians are concerned that there may be more adverse events if these guidelines are followed and that, without such protections, they will have exposure to additional liability. They also expressed concern that if guidelines establish a standard of care, and such guidelines are not followed, it exposes providers to liability.

The SIM planning team proposed to work with the Connecticut State Medical Society and liability carriers in the state to examine this question. The State will consider developing a program similar to those established by the Harvard Management Risk Foundation to identify risk reduction strategies for providers that will result in lower liability risk and reductions in premiums.

E) Consumer advocates are concerned about the risk to consumers under a shared savings program, particularly downside risk for Medicaid enrollees. With regard to the Medicaid population, particular concerns include the reduction of necessary access, inappropriate patient selection, and a contraction of the Medicaid provider network

Concerns in Connecticut were raised about possible risks of patient selection and denials of access for Medicaid enrollees if Medicaid adopted a downside shared savings program. For this reason, the Innovation Plan focuses on upside-only shared savings program arrangements in Medicaid.

In addition, the State will continue to develop a plan to evaluate risk avoidance and under-service for all populations. The Innovation Plan notes that it is important to establish program integrity functions that focus on these issues of risk avoidance and under-service, and that such functions should be separate and apart from quality measurement and continuous quality improvement activities. To this end, the Innovation Plan proposes to establish a separate Equity and Access Council comprised of consumer advocates, payer-based experts in audits and advanced analytics, and clinical experts and researchers from the state's academic health centers. The SIM leadership has invited Medicaid program integrity officials as well as the Medicare integrity branch to be involved in this discussion. The task of this Council will be to review the need for and recommend audit strategies and methods, both retrospective and concurrent, to help guard against these risks and to encourage payers to adopt such methods as they implement shared savings program arrangements. The State anticipates that payers will establish audit processes consistent with the recommendations of this Council.

Advocates also emphasized that practitioners that are found to be systematically or intentionally under-serving consumers should be disqualified from receiving shared savings payments. The guiding principles contained in our Innovation Plan have incorporated this notion: "Affordability of healthcare will not be achieved at the expense of quality healthcare. We will not reward the achievement of cost savings through inappropriate means, including under-service of patients" (p 9).