



State of Vermont
Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-2807
www.ovha.state.vt.us

[Phone] 802-879-5900

Agency of Human Services

Request for Proposal

September 15th, 2006

Consulting Services for Population Selection and Program Monitoring of Chronic Care Management and Care Coordination Programs

Responses to Questions from Written Submissions and Bidders Conference

The following questions were submitted in writing:

Background

1. Q: Page 6 - The RFP indicates that “All beneficiaries with at least one chronic health condition will be asked to complete a Health Risk Assessment (HRA) which will be administered by a separate survey vendor.” Normally, the Health Risk Assessment is an integral part of the disease management program service spectrum, and serves to begin the relationship between health coaching personnel and recipients. Will the state consider bundling the HRA with the same entity that is administering the Chronic Care Management (CCM) to enhance efficient, cost effective services? Can OVHA indicate potential timeframes for release and other information to enable potential bidders to prepare?

A: The CCMP HRA/intervention RFP is still in development; therefore it would be premature to give a definitive answer to this question. We anticipate the release of that RFP to happen this fall.

2. Q: Page 7 – The following questions are in reference to OVHA’s Care Coordination (CC) Initiative. What “real-time” data is available in the CC initiative? How will the CCM interface with this CC initiative? The RFP indicates two CC “teams.” Can OVHA provide additional information about expectations for these teams in terms of size and composition? Are additional teams contemplated?

A: It is anticipated that those hospitals that are participating in the Care Coordination Initiative will provide daily lists consisting of Medicaid beneficiary visits to the ER and hospital admission status. From these lists, Care Coordinators identify those beneficiaries who are eligible for enrollment in Care Coordination for whom intensive service coordination would be beneficial. Direct referrals generated by provider practices, independent community agencies and other areas of the Agency of Human Services provide current data for review in determining eligibility for Care Coordination. Within the Office of Vermont Health Access, real-time pharmacy data is available as well as Medicaid eligibility status.

The Care Coordination Initiative provides intensive service coordination for complex, high utilization Medicaid beneficiaries who represent the top 2% in total Medicaid expenditures and/or beneficiaries who consistently utilize high cost services. In either category, interventions are targeted for those beneficiaries who exhibit high utilization of the ER, those who are frequently hospitalized and those whose pharmacy costs are consistently high. The goal of Care Coordination intervention is to stabilize utilization patterns, establish access to appropriate services that maximize positive health outcomes. Once stabilized, beneficiaries can then be transferred to CCM for monitoring of long term appropriation of health care services.

Care Coordinator teams consist of one nurse(RN) and one social worker whose talents blend to develop comprehensive health care assessments and care plans, identifying physical health, mental health, and psychosocial aspects in need of coordination. Teams are strategically placed in State Agency Offices within statewide regional hospital service areas to enhance collaborative service coordination.

As OVHA plans for statewide implementation of Care Coordination, additional Care Coordinator teams are anticipated.

3. Q: What is the delay or lag in claims data?

A: Pharmacy claims are adjudicated at the point-of-sale; therefore we have daily claims information. All other claims are usually processed within 3 months, but may take up to 6 months.

4. Q: Can you provide specific, technical information about the feasibility of remote access to claims data for risk stratification and program evaluation?

A: The State is still determining how it wants to share data. It may allow the contractor to remotely access claims data, or it may choose to send the vendor a data file. If the State decides to allow remote access, the details of the technical approach would be negotiated based on the expressed needs of the contractor and those of the State.

5. Q: How are medical and pharmacy claims interrelated in Vermont? Are they part of one system?

A: Electronic Data Systems is responsible for Vermont's Medicaid Management Information System (MMIS) that includes both medical and pharmacy claims. They are the provider services' agent; process all claims other than pharmacy; and handle provider payments of all types. MedMetrics Health Partners (MHP) processes pharmacy claims and is Vermont's Pharmacy Benefit Administrator.

6. Q: Intervention strategies for children may differ substantively from those provided to adults. Will there be a lower (and/or upper) bound on the age of participants in the CM program? If children are included in the program, will the CM vendor develop separate interventions for children and adults with the same conditions?

A: There will not be age limitations on CCMP participants. However, the program will exclude Medicare recipients. It is likely that the vendor will develop separate interventions for children and adults, according to age-specific best practice guidelines.

7. Q: Will the vendor have the ability to exclude coverage of certain sub-groups (e.g., patients with HIV/AIDS or pregnant women)?

A: Legislation requires that this program serves all Medicaid beneficiaries with chronic health conditions; however we are open to consulting with the vendor on the best way to serve unique sub-groups.

8. Q: Will individuals with end-of-life conditions (e.g., cancer or other life-threatening disease with a prognosis of less than six months) be excluded (or treated separately) by the CM program or CC initiative?

A: See the answer to # 7 above

9. Q: Will individuals covered by any of the Medicaid waiver programs (i.e., Mental Health, MR/DD and TBI) be excluded from participation in the CM program or CC initiative? Will we have access to an individual identifier for participation in each waiver program?

A: See the answer to # 7 above. Yes, waiver participation identifiers will be available.

10. Q: In addition to hospitalizations and ER visits, other types of utilization that could be increased or decreased by better management of chronic conditions include some long-term care (LTC) support services

(institutional or community-based). Will the vendor manage long term care support services? Are data on who receives LTC support services available for use in selecting cases and/or evaluating program success?

A: This program excludes individuals receiving Medicare benefits, so the majority of Medicaid LTC beneficiaries would also be excluded.

11. Q: It would be useful to track which individuals participate in the CM program and CC initiative, reasons for non-participation and attrition, and the extent and types of individual participation, in order to adequately control for participation across programs. What types of information transfer will occur between the evaluation consultant and the CM vendors? Will these data elements be included?

A: We will look to the consultant contracted with as a result of this RFP to give us their data element requirements/requests during the monitoring design phase of this project.

General Procurement Information and Procedures

12. Q: Would Vermont release or support ready and timely access to Medicaid claims data for the past two years for designing the risk stratification and evaluation design?

A: Yes

13. Q: Will there be a remote broadcast/podcast of the September 5 session?

A: No

Technology Approach and Requirements

14. Q: In reference to the second bullet in Section II-G on page 21, is the vendor required to use SAS for all data analytical work (e.g., as opposed to other statistical software as SPSS, STATA, etc.)?

A: No, the vendor is not limited to the use of SAS for analytical work.

Scope of Work

General

15. Q: Can OVHA clarify how much of the required work over the two-year contract is focused on development and design versus specific analytical work resulting in empirical data assessing the CCM and CC Programs?

A: As stated on pages 26 and 27, we anticipate that approximately 5 months will be spent on development and design and the remaining months of the contract will be spent analyzing and assessing the CCM and CC programs.

16. Q: In reference to Section III-B Scope of Work Components on pages 26-27, there are no specific deliverables described after the first 5 months from the signing of the contract. Can OVHA describe specific deliverables that are expected for the remaining nineteen months of the contract?

A: As stated on page 27, the bidder will provide on-going selection and monitoring activities for the CCM and CC programs, to continue for the duration of the contract.

Selection

17. Q: Page 26 - How does OVHA anticipate the CCM contractor will be involved in study design?

A: As soon as the intervention vendor is identified, we will include them in discussions involving the design of the selection and monitoring systems.

Monitoring

18. Q: Would Vermont consider conducting a randomized trial or employing another controlled evaluation design?

A: We have not ruled out any options at this time and are open to discussing evaluation design and methodologies in depth as we go forward with this RFP process.

19. Q: Could Vermont assure access to the full array of CCM program cost information for the program evaluation, including program provider contracts, relevant Medicaid staff costs, and paid claims?

A: Yes

20. Q: Could Vermont assure access to clinical records for patients involved in a study of the effectiveness and cost-effectiveness of the CCM program?

A: Yes

21. Q: What organization is the data/claims intermediary for Vermont Medicaid, and could/would Vermont support requests to this data intermediary for special analyses for the CCM program evaluation?

A: Electronic Data Systems (EDS) is the claims processor for VT Medicaid. We may support limited requests for special analysis, but there are definitely resource issues to negotiate.

22. Q: What influence could the evaluation contractor have regarding the design of the intervention for the explicit purposes of program evaluation? For example, if the telephone center does data collection, will the evaluation contractor have access to those data?

A: The monitoring consultant will work with the intervention vendor and the State to develop intervention and monitoring strategies that are supportive of one another. Our intention is to be proactive in the program design to enable strong monitoring, but not interfere in the effectiveness or efficiency of the intervention.

23. Q: Could we build data-capturing into the intervention?

A: Yes

24. Q: Would the Pharmacy Benefit Manager and/or the Data Claims Intermediary (whichever is applicable in Vermont) be open to developing “triggers” that the vendor of the clinical services could use as accountable information, such as notifications to the program that a sentinel prescription has been written, or that an ER visit or hospitalization has occurred?

A: We are open to discussing these types of monitoring strategies with our claims processing partners.

25. Q: Will the evaluation group be responsible for producing data that the vendor of the clinical service may want in developing/improving the clinical program?

A: Yes

26. Q: Would Vermont support publication of evaluation results in peer-reviewed, professional journal?

A: Yes

27. Q: Will the evaluation consultant have input into the development of the Health Risk Assessment tool and access to the resulting data? As part of the HRAs, will it be possible to collect extra information on factors relevant to

evaluation?

A: The monitoring consultant will definitely have access to the HRA data. We are open to discussing input on the development of the tool.

28. Q. Activities undertaken by other State programs may influence the outcomes of the CM and CC programs. However, such activities may be difficult to track and quantify. Does the State foresee a requirement to control explicitly for the effects of other programs (e.g., the Blueprint for Health and the waiver programs, if applicable) to estimate the net effects of the CM and CC programs?

A: Yes. We understand this adds considerable complexity to program monitoring and evaluation; however we anticipate that a proactive approach to program design will assist in this effort.

29. Q. Some of the ‘covered populations’ described in the RFP have relatively small enrollments (e.g., Dr. Dynasaur). Does the State foresee a need to evaluate program results for each listed ‘covered population’ separately?

A. Not necessarily. We can discuss these details.

30. Q. How frequently does the State anticipate receiving reports from the evaluation consultant on program outcomes (e.g., quarterly, annually)?

A. The program consultant will play an integral part in the continuous quality improvement efforts of this program. Therefore, we anticipate frequent reporting, perhaps on a weekly or monthly basis.

Contracting

31. Q. As described on page 6 of the RFP, the vendor “selected as a result of this RFP will be ineligible to bid for the CCM intervention RFP”. What other RFPs related to the Global Commitment and the CCM/CC Programs would the selected vendor be ineligible to bid on? For example, is the selected vendor also ineligible to bid for future RFPs related to independent evaluations of the CCM and CC Programs – i.e., if a future RFP is released requesting bids for an EQRO to independently evaluate the CCM and CC Programs, would the vendor who received this current RFP be ineligible to bid on the EQRO RFP?

A. The consultant contracted to assist the State with program monitoring would be not be eligible to perform future independent program evaluations.

32. Q. What is the minimum and maximum budget that Vermont would provide to the evaluation contractor?

A. We have not determined those amounts.

33. Q. The type of quality measures that can be evaluated will be limited by the available budget (e.g., some outcome measures require medical record review). Can you specify the budget range the state is considering for the Population Selection and Program Monitoring award?

A. No

34. Q. The contract is set to start in early December, 2006, with a renewal date of July 1, 2008. However, section V-A of the RFP states that the contract term is 2 years. Should we budget for an 18 month period or a 24 month period?

A. The contract will minimally be for 24 months, although the needs of the State are subject to change after the initial 12 – 18 months.

The following questions were asked at the September 5, 2006 bidders’ conference

Q. Intervention components that are listed on page 6. Can you explain the relationship of your planning activities to define interventions, to define the cost benefits of those interventions, which then may drive some of the selection of metrics? How do you see all those pieces fitting together? Is the role of this contractor simply in the selection of the metrics for population monitoring or are there components of planning the interventions and determining the costs and benefits.

A. The RFP for intervention services is planned for release in early October. Legislation requires that RFP to be approved by the Health Care Reform Commission of the VT Legislature, so it would be premature to talk about that RFP. However, we can say that we will ask the bidders to set out a causal pathway, showing us what interventions they propose and what that will lead to in terms of changes in clinical measures and financial outcomes. Our overall goal is to improve people's health and save money. The State is looking for a vendor with expertise in this area to propose an effective intervention plan.

We have said that we would minimally like to look at HEDIS measures that are relevant to those particular chronic illnesses. Once we have established a causal pathway, describing the expected changes anticipated by the vendor, then we will have a better idea of exactly what we will measure. Generally speaking, we will need to know what changes are resulting as the program goes along. This is a collaborative partnership, so the consultant the State will partner with as a result of this RFP will be one of our partners as well the intervention vendor. The state will look for flexibility and collaboration, with all the partners on board with this project.

Q. Are you going to assess the particular impact of the CCM program? If so, what methodology will you use?

A. There are many different efforts working concurrently toward meeting the general goals of improving health and reducing costs associated with Medicaid beneficiaries with chronic illnesses. Those efforts include, among others, the Chronic Care Management program, Care Coordination which has started but hasn't been fully implemented and the Blueprint for Health which has started but has not been fully implemented. There are a lot of moving parts that will all affect the outcomes, and we acknowledge that the situation creates a challenge for monitoring the effects of a single program. We haven't yet defined a particular methodology, and in fact we are looking to bidders on this RFP to suggest the best approach.

Q. You say you are expecting that you will enroll approximately 25,000 in the program. How does that number relate to the overall Medicaid population, and how will you evaluate the effects of the program?

A. There are 116,000 beneficiaries that are not dually eligible. Those are the possible eligibles. There will be a smaller group that will actually be intervened with. We are not going to segment the population and serve some but not others. Everyone needing services will be included, but it is impossible to serve everyone on the first day. Therefore, there may be ways we can roll this program out to enable us to maximally observe changes. For example, if we reach out to 2,000 randomly-chosen beneficiaries every month across the state, we may be able to more effectively learn and observe the changes resulting from program interventions. We are opened for the best way to do this. We need to observe this process so we know what is happening and compare that to what would happen without an intervention as clearly and as confidently as we possibly can.

Q. Do those 116,000 beneficiaries include children and if so, will there be different programs for children?

A. It does include children, however, the intervention vendor may want to have a separate program or utilize best practices standards designed specifically for children. We also have to discuss how this will program will

interact with the existing waiver programs. We don't want to duplicate efforts. Will have to take a look at the sub populations and what will make sense.

Q. Do you have an idea of how you will operationalize how the different programs (Blueprint, Chronic Care Management, Care Coordination) and the various vendors will come together as a team?

A. That will be the State's responsibility. The State will have to form a steering committee or similar work group that will have everyone communicating with everyone else. Certainly the Blueprint will have to be a strong player in that steering committee because they have some best practice standards that they have already come to agreement on with other payers in the state. Whatever we are doing needs to be consistent with the messages the Blueprint program is giving to their patients and providers.

Q. Will pharmacy data be accessible?

A. Yes

Q. Reading the RFP it looks like the contract will start in December 2006 and renewed in 2008. It looks like an eighteen month period. Then elsewhere I read that the contract term is two years. I am wondering if the contract period will run for two years until December 2008 or whether we should budget for an 18 month period.

A. Sorry about the inconsistency, we intend to have two year contract minimally, but the needs of the state may change midway, either 12 to 18 months into this, so we wanted to leave opportunity to make any needed changes.

Q. How is the state going to manage the selection process? Many things can happen to the population as it is selected and transferred over to the intervention vendor. What is the roll out, how many are we going to give to the intervention vendor at one time? What if people decline enrollment? How is that process going to be managed?

A. We are looking for the consultant to help us with selection, meaning, an overall structure for the selection process. The timing of the delivery of sub populations to the vendor will depend on the intervention vendor's ability to roll out in coordination with the care coordination program. As we move forward in time we will refine the process of coordinating the roll out.

Q. Besides claims data, will we expect to receive information from medical charts, medical offices, from labs? What other sources besides claims data are going to be available to the vendor and how will the state assist the vendor in getting other sources of data?

A. At this time there is minimal infrastructure to make that information available. This is an area that the Blueprint is working on. It would be nice to have proposals talking about the types of data that would be helpful as we move forward and we can look at ways to improve the infrastructure. There are efforts being made in the state but it is in its infancy. We can more likely get lab data in a feed especially from our large medical institutions than the individual chart data in primary care physicians' offices on 30,000 people. For monitoring and evaluation, if you have a proposal for randomized collection that will help in monitoring the intervention vendor, so if we can collect 300 charts and get the data and that will be helpful in monitoring. That is again from a scalability perspective, we couldn't do that for the intervention vendor. We couldn't get

30,000 charts and digitize them all. Getting a small subset in order to help for program monitoring is a possibility. If someone has a methodology we are open for that.

Q. Sources of data such as global clinical records or VT health record run by the blueprint, would those be made available or would that have to go into our proposals?

A. Vendors should put into their proposals the type of data they would like to have made available to them.

Q. For example, BISCHA is working with the idea of a multi payer data set, where all of the payers submit all of their claims; would that be considered a possible source for data work?

A. What ever we have would be made available. There are a lot of things that are in concept but there are still periods of time down the road before they become a reality. Then once they exist there are still questions about what you need to do technologically to make them practically useful. There are also confidentiality and HIPAA requirements that have to be considered before you make that data available.

Q. Is the state willing to provide incentives to providers in an effort to exchange data?

A. Yes, we will be willing to consider it.

Q. Reports must show problematic outcome changes as compared to “what would have happened in the absence of the program”. Could some expand on the second part of that sentence in terms of defining what you are really looking for here?

A. We want to know the effect of this program. The only way we can really know what the effect of the program is, is to also understand what the effect would be without the program. Whatever monitoring system the consultant would set up would need to tell us “here is what would have happened without the program,” and “here is what happened as the result of the program.” Changes happen whether there is a program or not. We want to know the specific changes resulting from this program.

Q. Are the contractual terms in the document negotiable?

A. Generally no, unless there are unique circumstances to consider.

Q. Our firm had a contract with the Office of VT. Health Access, can we use the terms from that contract for this new scope of work?

A. Probably not, it would be a new scope of work. The contract would be based on that scope of work.

Q. Will the handout of questions and answers be available by email or on the site?

A. Julie will make sure they will be emailed to everyone that sent in a letter of intent.

Q. Are the list of companies who sent in a letter of intent available?

A. The following organizations submitted a letter of intent:

1. JSI
2. The Empyrean Group
3. Button Systems
4. Health System One
5. VPQHC
6. UMass Medical School Center for Health Policy and Research
7. Trajectory, Inc.
8. Regenstrief Institute
9. Milliman

The following organizations were represented either in person or by telephone at the bidders' conference:

1. JSI
2. APS Healthcare
3. Button Systems
4. Health System One
5. VPQHC
6. UMass Medical School Center for Health Policy and Research
7. Trajectory, Inc.
8. Regenstrief Institute
9. Milliman
10. Lewin Group

Q. Would you send that around when you send the questions and answers?

A. Yes.

Q. Is Vermont business identification required?

A. Yes. If you don't have VT business identification, please submit the VT Tax Certification form in appendix 6 and indicate that you intend to apply for one if your proposal is chosen.

Q. Would a vendor or subcontractor be precluded from bidding on a future RFP if they are bidding on this RFP for Chronic Care Management consulting?

A. The organization that assists the State with the selection and monitoring of this project can not also provide the intervention for this project. Nor can they be involved with a future independent evaluation.

Q. Part of the requirement is to coordinate efforts in with other waiver services through other departments at the Agency of Human Services. Can the State provide information about those waiver programs?

A. Yes, we certainly can provide information. A good place to start is the website for DAIL (Department of Disabilities, Aging and Independent Living) which is the department that manages most of the waivers, with the exception of the Mental Health waivers which are managed by the Department of Health. Links can be found from the Vermont.gov website.

Q. As the Blueprint makes final decisions on their approach on the way they are going to be going with their new registry product, will that have an impact on this RFP?

A. Not much of an impact on this selection process. This RFP process will be moving along with a consultant selected in the next few months and it's going to be a longer period of time before that registry component of the Blueprint system is going to be in a position to impact what we are doing.

Q. So, this really will be far more independent from their efforts.

A. It is a separate project and program. There have been questions on a couple of other information sources and it would be difficult at this point and time, to make promises about other data sources we might be able to make available because there are so many issues around that. There isn't a willingness to try to look at those data sources, but there just so many moving parts that the technology and the legal ability would all come together is something that we couldn't promise at this point and time

Q. When it comes to aggregate data, such as all of the different payer's HEDIS measures for Vermont, is that public data something we can use for comparative purposes?

A. Yes, any data that is already compiled and released is available.

Q. What happens when people are first enrolled beyond the health risk assessment? Is there a mandatory enrollment/passive enrollment process or will people opt in the program.

A. Well the program hasn't been developed yet. Maybe an opt-out strategy is the way to go. If someone wants to refuse to do the health risk assessment for example, they can do that. You can't force somebody to do that. We would take the attitude they are in unless they choose to opt out.

Q. When one comes eligible for Medicare by default this program is intended not to serve persons dually eligible for Medicaid and Medicare. What would happen in that situation?

A. If there are other services that they can access, which would be duplicative, then a referral would be made to other services. We would certainly look at the individual situation and see what makes sense. There is a waiver that is run by Department of Aging and Independent living (DAIL), another department in the Agency of Human Services. DAIL is responsible for Choices for Care, the long term care waiver that serves dual eligibles. That would be one possible referral source for people on this program should they age in to dual eligibility or become eligible for Medicare as a result of being disabled.

Q. Is Blueprint for more than just Medicaid? Does it also include commercial health insurance and other insurance in Vermont? How will that coordination occur regarding the Blueprint and this program?

A. Blueprint includes all payers in Vermont. We would want to coordinate with Blueprint activity. They are working on a patient registry, which is still in the development phase, and we would connect with that. We would provide information, as other payers do, to that patient registry. The Blueprint has some pilot communities where they provide more intensive provider education. The providers agree to do some activity around some disease, right now it is just diabetes. We would want to be consistent with the messages the Blueprint is giving to providers about how to care for their patients. Most of the commercial carriers are doing some type of disease management already. We have to be sensitive to realize that Medicaid has some unique

patient populations that are very different from commercial carriers and that is why we are here. We have a high degree of people with substance abuse and mental illness disabilities and we were created to take care of those people. In those areas, some commercial carriers that don't have such emphasis on those populations don't have such sophisticated or well developed intervention programs or strategies or they sub-contract certain populations out. I think our desire should be that we should be on the treatment protocol as when it comes to populations that we all have in common that we also should take in account this very unique population that Medicaid has.

Q. The intervention vendors have expertise in stratification; however, would there be the possibility of collaboration with the consultant in order to exchange ideas?

A. There are some hallmarks of this program that we keep repeating over and over again, which include collaboration, partnership, flexibility, and transparency. In terms of the stratification, the intervention vendors will bring their expertise. However, the monitoring consultant is encouraged to share their ideas on the subject as well. We want the best transparent stratification method.