

**Questions and Answers**  
**June 11, 2015**  
**Sustainability for Population Health Improvement**  
**DHMH-OPASS-15-14546**

**Q1. What is the expected length, or is there a page limit, for the draft and final deliverables (e.g., 25 pages? 100 pages? 500 pages?)?**

There is no page limit, although offerors are encouraged to be concise.

**Q2. Is there a page limit for the proposal, or any of sections of the proposal? If so, does the page limit exclude resumes, table of contents, transmittal letter, or any other items?**

There is no page limit.

**Q3. What expectations are there around how much time the team spends on-site in Baltimore?**

The contractor is expected to be available in person for the kick off meeting, the Summit, and for occasional meetings. Expectations for in-person meetings will be discussed in greater detail at the kick-off meeting.

**Q4. In the description of the report deliverables on p. 25 of the RFP, the requirements and timing for preliminary, draft and final reports are described (e.g., "two weeks from delivery of the draft final report [for DHMH] to provide comments on the report back to the contractor."):**

**1. To what degree is the State looking for a fully independent report versus expecting DHMH and/or other stakeholders to provide significant input on the substance of the findings and recommendations in the report?**

The vast majority of the content will be generated from the contractor. Assuming the contractor fully addresses the required report components as outlined in the Scope of Work, is responsive to the feedback from the preliminary report, and appropriately includes/takes into account other delivery reform efforts in the state, DHMH anticipates making only minor changes to the final report.

**2. How many reviewers does the State anticipate will be involved?**

We anticipate no more than 10 reviewers from state agencies.

**Q5. Are there specific reports that the State would like us to leverage as we compose the draft and final deliverables?**

Yes. DHMH expects the contractor to make itself aware of key and related delivery system reform projects, including HSCRC All Payer Model workgroups and Regional Partnerships, and to include recommendations and other findings from these groups into the draft and final deliverables. DHMH will provide guidance throughout the contract period on specific reports and other items that should be included.

**Q.6 What, if any, important dates are there beyond those specifically mentioned in the RFP?**

There are none to report at this time.

**Q7. Who is the executive sponsor of this effort?**

The Deputy Secretary for Public Health Services at DHMH.

**Q.8 What level of involvement has been committed by the State of Maryland for the Offeror to engage with on a regular basis (e.g., half-time Project Manager, etc.)?**

Three staff members of varying seniority and responsibility will commit between 10 and 25 percent of their time to this contract and directly related work, depending on the phase of the contract. It is anticipated that more staff time will be devoted to the contract around when deliverables are due and around the Summit.

**Q.9 What is the time horizon for the financial model requested in section 3.2.2, page 24?**

The time horizon should run through the year 2025 at a minimum and should take into account the potential transition to a Phase II (Total Cost of Care test) in the All Payer Model in 2019. Offerors are encouraged to include longer time horizons in the financial models. See Maryland's agreement with CMMI, available on the HSCRC website, for more details.

**Q10. Is there an ROI target for the program (please refer to section 3.2.2, page 25)?**

No. The contractor should estimate ROI based on the most promising evidence based strategies and existing and proposed financial mechanisms. The All Payer Model does have financial savings targets, however. Total hospital per capita revenue growth must be held to 3.58% in the first 3 years of the All Payer Model. In addition, Medicare spending must result in savings of \$330 million over 5 years compared to the dynamic national trend. Based on current estimates, this means Maryland's Medicare spending needs to be about 0.5% lower than the national trend over that time period. Please review the state's agreement with CMMI for more details.

**Q11. May we provide representative resumes for junior analysts/consultants?**

Yes, this is acceptable.

**Q12. For more senior team members, is it permissible to provide the names of up to two people for each team member position (understanding, of course, that there is a set of guiding principles regarding substitutions)?**

Yes, this is acceptable, although we would prefer that the offeror definitively state who the most senior team member will be and provide their resume.

**Q13. Are Green card holders or other non-U.S. citizens with a legal right to work in the U.S. eligible to be part of the team?**

This question is under review, the Department will respond as soon as possible.

**Q15. What is the estimated budget for the effort?**

The Department is not providing an estimated budget.

**Q16. Is the contract fully funded for the scope of services in this RFP?**

Yes, enough funding has been set aside to fully fund the scope of work by our estimation.

**Q17. Section 1.16 states that offerors may be required to make oral presentations to State representatives. Are such presentations likely to occur and, if so, what is the approximate timeframe?**

Oral presentations are not anticipated, but we reserve the right to require them. Offerors will be given at least two weeks notification prior to such a presentation.

**Q18. If possible, please let us know if there is an incumbent for this contract, as well as who it is?**

There is no incumbent for this contract.

**Q19. We understand the Population Health Strategy will guide the use of resources saved through the global payment model for reinvestment in population health strategies for long term savings. Are there any set targets for the amount to saved through the implementation of the population health strategy?**

Per Maryland's agreement with CMMI, total hospital per capita revenue growth must be held to 3.58% in the first 3 years of the All Payer Model. In addition, Medicare spending must result in savings of \$330

million over 5 years compared to the dynamic national trend. Based on current estimates, this means Maryland's Medicare spending needs to be about 0.5% lower than the national trend over that time period. Please also review the recently released All Payer Model results for 2014, available on the HSCRC website.

**Q20. Is there any information on the cost savings achieved thus far through population health initiatives in Maryland, such as hospital re-admissions? If yes, can the methodology for calculating these savings be shared?**

We will discuss this issue in the period between selection of a contractor and the Go-Live date.

**Q21. How has the community integrated medical home been initiated and woven into the population health strategy? Has there been any analysis on the impact of the community integrated medical home that can inform this work?**

The Community Integrated Medical Home (CIMH) was to be implemented using funds from a SIM Round 2 Model Testing award. Instead of this award, Maryland received a smaller Model Design award to engage in additional planning. There are no plans to implement the CIMH at this time.

**Q22. Given the number of Maryland residents who receive care in the District of Columbia, will the contractor be provided utilization data for the District of Columbia data in order to assess full healthcare utilization of Maryland residents?**

The focus of this contract is on the All Payer Model, which only includes Maryland hospitals, and other Maryland delivery system reforms. However, data are available on Maryland residents' utilization of District of Columbia hospitals. DHMH can assist the contractor with obtaining these data if the contractor determines it is need.

**Q23. Can you please specify all of the SIM HSRC workgroups whose recommendations that would be included in the Report on Sustainability for Population Health. Are there groups beyond the Care Coordination, Regional groups, and Physician Alignment Groups?**

These are the primary groups. Offerors should use their own expertise and judgment to identify other workgroup recommendations and other delivery reform related reports and documents that are relevant to this project.

**Q24. Have there been regional needs assessments other than the hospital community benefit and the Local Health Improvement Coalitions (LHIC) that should be used to inform the population health approaches at the regional level; including inventories of assets, resources, and analysis of target populations for interventions?**

Not on a widespread scale. DHMH will make the contractor aware of any such documents.

**Q25. We understand that the regional health partnerships interim report is due Sept 1, 2015, and final report is due December 1, 2015. The final report for this contract is due December 31, 2015. Given that the final Regional Health Partnerships for Health System Transformation report will not be available until after the due date of the preliminary state population health strategy (October 15<sup>th</sup>), can you clarify the expectations of how the final reports of the Regional Health Partnerships should inform the statewide population health strategy?**

DHMH expects the Regional Partnerships' strategies, which have already been outlined at a high level, to be incorporated into the service/intervention approaches as well as the financial model(s). The timeline for this contract has shifted, and more detailed information from the Regional Partnerships will now be available earlier in the contract period.

**Q26. In section 3.2 Scope of Work, on page 25 it states the draft final report is due 12/31/2015. DHMH has 2 weeks to comment on it (Thursday 1/14/16). But the Contractor must incorporate edits and submit a revised final report by 1/15/16. Does the contractor have only one day to make edits?**

This project timeline will likely be revised. Please look for amendments to the RFP.

**Q27. Section 3.2.3 states that the Population Health Summit should occur between Sept 15 and December 1 and should be used to present options from the preliminary report. Since the preliminary report is due October 15<sup>th</sup>, is it intended that the summit should occur between October 15<sup>th</sup> and December 1?**

This project timeline will likely be revised. Please look for amendments to the RFP.

**Q28. Would claims data be provided at the outset of the contract Medicare, Medicaid, and private, at the state and county level? Does a time frame for data delivery need to be built into the workplan? Would claims data be provided at a county or zipcode level? What format would this data be provided in?**

DHMH will work with the contractor during the period between selection and the Go-Live Date on submitting DUAs and other paperwork necessary to receive HSCRC utilization data, which includes de-identified, patient-level inpatient, outpatient, and ED utilization data from 2008-2014 from all Maryland acute care hospitals. These data are all-payer and include patient's ZIP code, county of residence, payer(s), and charges. Data will be provided in SAS file format.

**Q29. Is there a defined role of VHQC (Maryland and Virginia Quality Innovation Network) in the development of a population health strategy?**

No, although the contractor should consider VHQC and its initiatives in developing strategies.

**Q30. Given the tight time frame, what data will the state agency provide? We understand that the Regional Health Partnerships were provided the following data: Descriptive tables for the subject area concerning 2013 utilization of hospitals, ERs, SNFs by Medicare beneficiaries; description of the number of FFS Medicare beneficiaries and subsets by diagnosis, age, residence; readmissions and Hospital Acquired Conditions for Medicare; and Census data. Would this same data be available at state and regional levels to the contractor?**

Yes, these data will be available to the contractor, in addition to HSCRC utilization data, which includes de-identified, patient-level inpatient, outpatient, and ED utilization data from 2008-2014 from all Maryland acute care hospitals. These data are all-payer and include patient's ZIP code, county of residence, payer(s), and charges.

**Q31. Will there be any costs to the contractor for data acquisition?**

There are no costs associated with obtaining HSCRC and other state datasets. The contractor may incur costs should they attain additional data from non-state sources.

**Q32. Given the short time frame is primary data analysis expected? Would initial analysis of claims data or summary analysis be provided that has been done by other HSRC workgroups?**

Yes, we do expect the contractor to conduct primary data analysis. However, previous analyses may be incorporated where appropriate and feasible.

**Q33. Is there ability from the claims dataset to link claims to provider systems and ACOs?**

The HSCRC utilization data identifies the hospital on each encounter.

**Q34. Can more information be provided on the 4-5 regions and how they are defined?**

Summaries of the projects, including how they are defined, are publicly available on the HSCRC website (see the press release on Regional Partnerships). Complete proposals and other documents may be available to the contractor.

**Q35. Is theft insurance an absolute requirement? Are subcontractors required to meet the same insurance requirements?**

The requirements under Section 3.4 Insurance Requirements will not be revised. All requirements are the responsibility of the *prime* Contractor awarded this contract resulting from this solicitation.

**Q36. Is there a requirement that staff be located onsite of HSCRC during the contract period performance?**

There is no requirements to be onsite at HSCRC; this contract is not being issued by HSCRC. There is no requirement that the contractor be onsite at DHMH, which is issuing

**Q37. Per page 37, Section 4.5 dictates that the Financial Proposal should be presented in a separate Volume (i.e. Volume II), and the Offeror shall submit an original unbound copy, four copies, and an electronic version in Microsoft Word of Microsoft Excel. Section 4.5 further explains the Financial Proposal shall contain all price information in the format specified in Attachment F, and that the Offeror shall complete the Financial Proposal Form only as provided by the instructions in Attachment F.**

**Per page 66 and 67, we understand that the Financial Proposal Form solely asks for a Total Proposal Price. We further understand that we are to complete this Financial Proposal Form only and not deviate from the Financial Proposal Instructions. Therefore, we understand that Volume II should not include any information other than a total price, such as Offeror's standard rates, calculations of expected time, calculations of expenses, etc...**

**Please confirm that Volume II shall only constitute a Total Proposal Price as depicted on page 67 of Solicitation No. DHMH/OPASS 15-14546 and no further information supporting reasoning for the total proposal price or a more comprehensive Financial Proposal.**

Note that the Financial Proposal Form clearly state that is not to be amended. Financial proposals will be evaluated by the fully loaded fixed price submitted.

**Q38. Is the kick-off meeting the official start of the project? Will the contractor have access to HSCRC resources is before the kick-off meeting to ensure the preparation of the work plan draft captures the scope and expectations appropriately?**

The period between the contract initiation and the Go-Live Date is the startup period. DHMH will assist the contractor in obtaining the HSCRC data during the startup period. This process should not take more than a few weeks. The official start of the project is the Go-Live Date. The kickoff meeting will be held soon after the Go-Live Date.

**Q39. As per our experience, this type of engagement requires multiyear clinical and financial data from hospitals as well as claims data. What are the data sources that state has access in order to perform this engagement? Can you please provide the detailed list of data sources?**

The contractor will, at a minimum, have access to de-identified, patient-level inpatient, outpatient, and ED utilization data from 2008-2014 from all Maryland acute care hospitals. These data are all-payer and include patient's ZIP code, county of residence, payer(s), and charges. Data will be provided in SAS file format.

**Q40. There is a mention of 46 acute care hospitals in Maryland operating under global budget. For**

**developing funding mechanisms as specified in the scope, are these 46 acute care hospitals in scope OR any additional entities will need to be considered?**

Yes, these 46 hospitals are in scope and the model should revolve around these hospitals. Additional entities, such as those participating in Regional Partnerships, should be incorporated as well.

**Q41. Does award of this work preclude the contractor from bidding on any subsequent SIM related work?**

No.

**Q42. Will DHMH allow exceptions to stated terms, including, but not limited to an additional limitation of liability statement?**

See Section **1.24 – Mandatory Contractual Terms** - as stated, any exceptions shall be clearly identified in the Executive Summary of the Technical Proposal. This section further states that a proposal that takes exceptions to the terms and conditions may be rejected.

**Q43. What internal State offices would serve as the internal stakeholders for this work?**

HSCRC, the Maryland Health Care Commission (MHCC), and Medicaid Planning Administration. Additional internal stakeholders may be identified at a later date.