# Vermont Green Mountain Care Board
# Responses to Analytics Contractor RFP Bidder Questions
# February 5, 2014

## Programmatic context

1. In terms of its impact on assessing the VHCURES database, what is the current payment methodology used by entities participating in the ACOs?

   *For 2014 providers participating in the ACOs will generally be paid on a fee-for-service basis by the participating payers.*

## Patient attribution methodology

2. How will ACO membership be attributed for enrollees who do not have a plan which requires selection of a primary care physician and do not have any claims in the last two years?

   *For the commercial ACO pilot program, the patient attribution methodology states that enrollees will be attributed to an ACO first in accordance with the enrollee's selected primary care physician (PCP). All Exchange-based plans require identification of a primary care provider. However, if for some reason, the enrollee has not selected a PCP, then the claims will be reviewed using a predefined algorithm.*

   *For the Medicaid ACO pilot program, beneficiaries will be attributed to an ACO based first on claims data, then by PCP selection if there is no claims history, and finally by PCP assignment if the beneficiary has no claims history and has not selected a PCP. If the beneficiary changed primary care provider selection during the year, then the beneficiary is attributed to the primary care provider to which he/she was attributed as of the end of the year. DVHA requires Medicaid beneficiaries to designate a primary care provider and assigns a primary care provider to those beneficiaries who fail to do so.*

3. The commercial ACO attribution methodology indicates that insurers will run their attributions at least monthly. For each evaluation period, may members be assigned to multiple ACOs?

   *Members may be attributed to only one ACO for an evaluation period with a given payer, but could conceivably be attributed to more than one ACO across Medicaid and commercial payers should the member's coverage change during the course of the evaluation period.*

## Provider affiliation methodology

4. How will physicians with multiple practice or ACO affiliations be tracked?

   *Each primary care provider is limited to participation in one ACO and as such will be reported to the payers as an ACO network provider. If during the year the provider terminates his/her relationship with the ACO, the ACO will submit this information to the payers. The payers and ACOs have agreed to share this information on a monthly basis using a standardized report form.*

## Questions regarding the data that the Contractor receives for analysis

5. Will the claims data be submitted by the provider directly to the contractor or can VHCURES be leveraged to calculate quality measures?

   *For the purpose of calculating the claims-based quality measures (Core Measures #1-13 for Year One), the payers will submit all of the claims files to the Contractor. The Contractor will need to be able to receive these files, calculate the rates and compile a report on the basis of these submitted files. The GMCB is asking the Contractor to assess the viability of using VHCURES as the source of claims data for quality measure and savings calculations in future.*

6. Will payers be responsible for transforming data into a standard model for analysis or is the vendor responsible for this work?

   *The payers are responsible for submitting claims filings using the standard format required for submission to VHCURES.*

7. The RFP states the contractor will receive data from the Participating Payers in the VHCURES format. Will this data include any type of indicator that would help the Contractor know which claims should be included in the calculation and which claims will need to be excluded (e.g., adjustments, denial, duplicates, etc.) or should the Contractor assume that data cleaning will be necessary?

   *The participating payers are responsible for providing only those claims which should be included in the calculations.*

8. In what form or format will data for the quality measures, notably the clinical quality measures, be submitted to the Contractor? Will ACOs be expected to supply just the numerators and denominators, or will they provide additional information, such as age, gender, region, and other demographics?

   *For the Core Measure Set claims-based clinical quality measures, the payers are responsible for submitting claims filings using the standard format required for submission to VHCURES. For the Core Measure Set clinical data-based quality measures, the ACOs will provide numerators and denominators to the Contractor. For the Monitoring and Evaluation Measure Set, the payers will submit numerators and denominators to the Contractor.*

9. For the survey-based quality measures, does GMCB already have a firm under contract to conduct the surveys? When is the anticipated start date of the surveying?

   *The state has issued an RFP for a contractor to generate the survey-based quality measures. The survey work is to be completed prior to the time when the Contractor will need it for the defined scope of work.*

## Methodology for expected, targeted and savings calculations

10. The RFP states that the savings calculations shall be performed using claim data submitted by Participating Payers. Is that also the case for the Expected Costs PMPM or

will this data be provided differently? If differently, please explain the data that will be provided for this first step.

*Yes, the saving calculation shall be performed using claims data submitted by the payers. For details on the commercial pilot, please see pages 39-40 of Attachment F. For details on the Medicaid pilot, please see pages 50-51 of Attachment G.*

11. Will the Medicaid expected costs PMPM include only claim-based services found in VHCURES or will off claim costs be included?

    *Only claims-based costs are to be included for Year One calculations.*

12. Will actuarial certifications be required by GMCB in the development of the expected, targeted and savings estimates?

    *No.*

13. The RFP states "Re-price core service expenditures to base year." Should this instead state "Re-price core service expenditures from base year to projection year?"

    *The language in the RFP is correct. The benchmark years are re-priced to payment policies in effect in a base year. The observed rate in growth of utilization from re-priced benchmark years is then used to trend the base year to the performance year per the methodology for computation of expected expenditures.*

14. Will the Contractor be responsible for re-pricing the Medicaid claims as specified in Attachment G?

    *Yes, with support from DVHA. Please also see the response to question #13.*

15. Do you anticipate the vendor will need to have an actuary involved in the rate setting or baseline performance cost setting and tracking?

    *No.*

## Risk adjustment

16. We note the guidelines specify CMS HCC methodology for risk adjusting the population. Is the state willing to consider alternate methods of risk adjusting for population illness burden?

    *For Year One the Medicaid ACO pilot requires the use of the CMS-HCC (Hierarchical Condition Categories) prospective risk adjustment model and the commercial pilot requires use of the risk adjustment model utilized by CCIIO for the federal exchange. The GMCB and DVHA may consider alternatives for future years.*

17. In Step 3 in Attachment F, it mentions applying a case mix adjustment (rather than risk adjustment) to the actual spend. Is there a reason the same risk adjustment methodology would not be applied in the development of expected and actual claims?

    *"Case mix adjustment" should read "risk adjustment." The same risk adjustment methodology should be applied throughout the process.*

## Measure calculations and benchmarks

18. Will the Commercial ACO Pilot use the HEDIS PPO benchmarks for Years 2 and 3?

    *This has yet to be determined. The state's Quality and Performance Measures Work Group and the Payment Models Work Group are scheduled to review all targets and benchmarks for the measures designated for payment purposes at the beginning of the third quarter of each pilot year.*

19. What is the quality benchmark methodology for the Medicaid ACO pilot?

    *For Year One, the targets for the Medicaid ACO pilot are either based on the 2012 national HEDIS benchmarks for Medicaid or state-developed Medicaid benchmarks. Additional detail will be provided to the Contractor after the contract start date.*

20. Attachment G specifies both benchmark and base years. Could GMBC provide additional clarification as to the definition of each type of yearly measurement period?

    *Please review the definitions provided in Section I. D. of Attachment G. The final calculations will be provided, with support from DVHA.*

21. Could GCMB categorize each of the 23 Monitoring and Evaluation measures as cost, quality, or utilization? Specifically, could GCMB identify which measures the Contractor will need to develop?

    - *Monitoring and Evaluation measures 1-6 are claims-based quality measures that will be calculated at the payer level. The payers will submit numerators and denominators to the Contractor for inclusion in the Contractor' annual Monitoring and Evaluation report. These measures are not calculated at the ACO level and therefore the Contractor will not be required to calculate the rates for these measures using claims files.*
    - *Monitoring and Evaluation measures 7-9 are measures that will be submitted to the Contractor from non-ACO sources. The Contractor will not be required to calculate these measures.*
    - *Monitoring and Evaluation measures 10 and 11 are cost measures and will need to be calculated by the Contractor on an annual basis.*
    - *Monitoring and Evaluation measures 12-23 are utilization measures and will need to be generated by the Contractor on a quarterly basis using numerators and denominators supplied by the payers to the Contractor.*

22. Are the measures listed in Attachment I the only measures that will be required for the pilot?

*The measure set required by the pilot is subject to annual review and may be modified or expanded in Year Two and/or Year Three. Please see Section X of Attachment F for more details.*

## Process, format and timing of reports

23. Is it expected that the reporting system will be required to provide patient-level drill down to any relevant metrics?

    *No.*

24. The RFP states in a number of places the analytics contractor will supply the ACOs with reports. The RFP is a bit unclear about the process and mechanisms for doing that, and what to do about questions that the ACO's and individual providers may have about the results, or the data used to create the measures and reports. Where will those questions go?

    *The GMCB has yet to finalize how reports will be distributed to ACOs, but anticipates the Contractor will do so via electronic means after review and approval by the GMCB and (for Medicaid experience) DVHA. The GMCB also has not yet determined how ACO (or payer) questions regarding reports will be handled. The GMCB does not anticipate that it will be the responsibility of the Contractor to respond to questions submitted to the Contractor by ACO providers.*

25. With what frequency will data receipt, measure calculation and reporting be carried out (i.e., annually or more frequently)

    *Measure calculation will take place in accordance with the timeline provided in Attachment M: Timeline for Measure Generation and Reporting.*

26. Can you provide guidance on your expectations for when tasks listed in Attachment H will be due? For example, the first three tasks listed have a due date of January 31, 2014.

    *The GMCB currently anticipates that January and February deliverable dates will be extended to May 31st and June 30th, respectively. All other due dates shall remain as defined in Attachment H.*

27. Are reports only due for Section 3.2.A-D tasks?

    *No. Section 3.3.A of the RFP is hereby corrected to read as follows:*

    *"The Contractor shall produce reports that provide the results of tasks undertaken to fulfill Section 3.2.A-D and Section 3.2.E.3, 3.2.E.5, 3.2.E.6 and 3.2.E.7 responsibilities."*

## Review of Contractor reports

28. Is there expected to be a review/protest period during which ACOs can contest or request a review of their measure results and payment calculation? If so, what is the role of the vendor?

*While there is no defined review or "protest" period, the GMCB does anticipate that the Contractor will respond to questions regarding computational results raised by the GMCB, DVHA and by participating ACOs and commercial payers. The GMCB will define the process for question submission and review with Contractor input after the contract start date.*

29. Will there be data reviews with the state before reports are issued so they know what the results are before they go out?

    *Yes. The GMCB and DVHA will review Contractor reports prior to distribution to participating payers and ACOs.*

## Sample identification/ generation

30. Could GMCB please clarify how the Contractor will be able to identify eligible individuals for the purposes of selecting a sample? Will this task require a separate data submission from the ACOs to the Contractor?

    *The GMCB anticipates that the Contractor will need to analyze a claims file submission from the participating payers for this purpose.*

31. Is it anticipated that the contractor vendor will conduct the medical record chart reviews or simply provide the random sample for the ACOs to use in conducting the record review?

    *If the ACO chooses to conduct chart review as the basis for collecting the clinical data-based quality measures, then the ACO will be responsible for conducting these reviews. The GMCB anticipates that the Contractor will only be responsible for providing the ACO with a randomly generated sample.*

## Coding changes report

32. Can you provide clarification on the methodology for determining how coding changes affect costs? Is it based on reviewing how many times a provider submits a code for reimbursement year over year, or is there a different method for calculation?

    *The GMCB is looking to the Contractor to recommend a methodology for calculating the impact of coding changes on costs.*

33. The RFP states, "The Contractor shall conduct an annual assessment of the financial effect of changes in medical coding practices on ACO expenditures." Could GMCB please clarify whether this refers to one specific type of medical coding or a broader range of medical coding (e.g., ICD-10, bundled payments)?

    *The GMCB is interested in the impact of general changes in provider coding patterns on costs.*

## Questions about other potential requirements of the contract

34. Could GMCB please provide any examples of what "Other Measures" may be requested?

*These include measures such as the school completion rate and unemployment rate measures found in the Monitoring and Evaluation Measure Set.*

35. Please elaborate on what is intended regarding "assessment of timeliness and completeness of the VHCURES database." Specifically, should the Contractor assume that "completeness" refers to the extent that variables are populated (i.e., data quality analysis) or the amount of run out time for the submitted claims (i.e., lags in claim submission and/or processing will influence "completeness")?

    *By completeness, the GMCB is currently primarily interested in whether variables are populated and all specified provider claims are contained within VHCURES. The GMCB will provide more specific direction following the contract start date.*

36. Could GMCB please provide some examples of topics on which ad-hoc reports may be requested? Could GMCB provide any guidance, for budgeting purposes, how many ad-hoc reports can be expected in each year of the contract?

    *The GMCB recognizes the difficulty in estimating the effort required to respond to this requirement. While the GMCB does not anticipate that either it or DVHA will create high volume of requests, it does anticipate that periodic analyses may be requested to monitor pilot impact and to inform planning for future activity.*

## Geographic requirements:

37. On page 6, the RFP states that work may be performed at the contractor's office location. Page 16 states that as a general rule, project work will be done in Montpelier, VT. Can you please clarify your expectations for where the work for this RFP will be performed?

    *We recognize the confusion in the language in different sections of the RFP. We recommend that the Contractor budget visits to Vermont once per month, with eight of those visits being a one-day visit and four visits being for two days. Otherwise, working from the Contractor's home office is acceptable with availability during normal business hours for calls, etc.*

## Evaluation/ requirements for the bid/ RFP response

38. Are the listed Evaluation Factors provided in order of importance?

    *No.*

39. Could GMCB please clarify the Evaluation Factor "Availability and Flexibility?"

    *The GMCB believes that the RFP provides sufficient clarity.*

    *It will be important that the Contractor is reasonably available during business hours to respond to questions from staff on an unscheduled basis. Flexibility assumes a willingness to work with the ACOs, payers, and staff to consult and problem solve with us if we encounter unanticipated issues related to the implementation of the shared savings program.*

40. In terms of the "Presentation" Evaluation Factor, is this referring specifically to the presentation of the proposal?

*No, this would include an evaluation of the Contractor's experience, references, skills, etc. The GMCB believes that the RFP provides sufficient clarity.*

41. Should the proposal meet any page limit requirements or does GMCB have any requirements for other formatting elements (e.g., font size for text, font size for graphic, margins)?

    *There are no such requirements. Submissions of excessive length should be avoided, however.*

42. Should bidders present the required elements (i.e., References, Technical Bid, Organizational Experience) in the order provided in the RFP or do bidders have flexibility in how information is presented?

    *It would be preferable if the bidders presented the elements in the order provided in the RFP.*

43. The RFP states that bidders should "describe their qualifications for meeting the Professional Service Requirements in Section 4." However, Section 4 of this RFP addresses the Method of the Award. Could GMCB please clarify where the Professional Service Requirements can be found in the RFP?

    *Bidders need not describe qualifications for meeting Professional Services Requirements.*

44. Is GMCB requiring that references be provided for the bidder as an organization or for each person being bid? If references are required for each person being bid, is it acceptable to limit this to individuals considered by the bidder to be "key personnel?"

    *References should be for work performed by the bidder organization that involved the lead staff persons for the proposal.*

45. The RFP, in two locations of this section, requires organizational references. Could the GMCB please clarify how many references are required? Are references needed for all projects cited to support organizational experience?

    *By references, the GMCB here means the names of client organizations in reference to the bidder's described experience. Bidders should provide at least three organization references.*

46. The RFP states, "Section 4 of this RFP (Scope of Work) shows the interface between the GMCB's responsibilities and the Contractor's responsibilities." Could GMCB please confirm that bidders should actually refer to Section 3 of this specific RFP for the Scope of Work?

    *Yes, the GMCB so confirms.*

47. Item 3 in the cost bid instructions requests an hourly rate for each staff class for Section 3.2.E.3 tasks. The task under 3.2.E.3 is a sample of measure-eligible patients for medical

record review. Is this the only task funded on an ad-hoc basis? If not, what other tasks would be funded on an ad hoc basis (3.2.E.4 ad hoc reports for example)?

*There was some erroneous information within subsection of Section 5.3 of the RFP titled "Cost Bid." That subsection is hereby corrected to read as follows:*

***Cost Bid:*** *The bidder should offer a cost proposal, distinct from the technical proposal. The cost proposal shall be structured as follows:*

1. *Fixed price proposal for each year of CY 2014-17 for Section 3.2.A-D and 3.2.E.3, 3.2.E.5, 3.2.E.6, 3.2.E.7 tasks and the assigned staff class and corresponding hourly rates used to construct the fixed price proposal.*
2. *Fixed price proposal for each year of CY 2014-17 for Section 3.2E.1-2 tasks and the assigned staff class and corresponding hourly rates used to construct the fixed price proposal.*
3. *One hourly rate for each staff class for Section 3.2.E.4 tasks (i.e., ad hoc requests).*

*The aforementioned cost proposal shall be exclusive of travel-related costs. The bidder should budget visits to Montpelier or Burlington once per month per calendar year, with eight of those visits being a one-day visit and four visits being for two days. Any contract written as a result of this RFP will require receipts for all expenses other than vehicle mileage or will use per diem rates specified in the "General Service Administration (GSA) Per Diem 2000 study" for lodging, meals and incidentals. Vehicle mileage will be reimbursed at a rate determined at the time the contract is executed. The Contractor must bill the GMCB for work performed at least once a month.*

*For all work performed except for that relating to Section 3.2.E.4 tasks, the GMCB intends to pay the Contractor based on contracted hourly rates up to a maximum defined by the contracted fixed price proposals.*

48. Must the Business Associate Agreement be signed and submitted with the proposal, or will the winning contractor sign it after award?

    *The agreement is to be signed by the Contractor, and not by the bidders.*

49. The RFP states, "The bidder should offer a cost proposal, distinct from the technical proposal." Does the State require a separately sealed cost proposal, or can the cost and technical proposals be included as separate sections within one document?

    *Bidders may submit cost proposals and technical proposals as separate sections within one document.*

50. The RFP states, "A redacted copy should be included for portions of submittal that is not proprietary." Should the redacted copy be included in electronic (emailed) form, or in hard copy?

    *The redacted copy should be included in both electronic and hard copy forms.*

51. The Technical Bid section references a "Contractor Responsibilities" section. Please clarify where in the RFP the Contractor Responsibilities can be found.

    *The "Scope of Work and Contractor Responsibilities" section should be understood to mean Section 3 ("Scope of Work").*

52. The third paragraph of the Technical Bid section references a Section 4 (Scope of Work). Should that be Section 3?

    *Yes.*

Finally, the GMCB notes that proposals shall be reviewed by state staff and other stakeholders as designated by the GMCB.