

*Colorado Department of
Health Care Policy and Financing*



Request for Proposals
RFP # HCPFKQ1103SDAC

Statewide Data and Analytics Services
for the Accountable Care Collaborative Program

Modification No. 3

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SECTION 1.0 INTRODUCTION

The Colorado Department of Health Care Policy and Financing (the Department) is soliciting competitive proposals from vendors with experience and expertise in health data analytics, business intelligence, and program evaluation to support the administration of the Colorado Medicaid Accountable Care Collaborative (ACC) Program as the Department's Statewide Data and Analytics Contractor (SDAC). The Department is seeking an organization with a minimum of five years of experience building, operating, and maintaining a data warehousing capability; a minimum of five years of experience using sophisticated analytics for performance evaluation of complex programs; and a minimum of three years of experience developing and hosting a Web Portal that includes ongoing help desk support for end-users.

The SDAC and the information provided by the SDAC will be an essential element in the management of the ACC Program. Central to the overall management of a Client's health care is the availability and analysis of critical data to better align provider payments with health outcomes as well as identify appropriate interventions that can dramatically improve the health of Medicaid Clients. As result, the Department recognized the need for a Contractor to support the ACC Program through statewide data collection and analytics.

One of the ways to promote accountability in the health care system rests on developing better performance metrics. Through data analytics and reporting activities, the SDAC will assist the Department in assuring that the ACC Program goals are consistently met in an effective and efficient manner.

The responsibilities of the SDAC will include:

1. **Client Selection for Program Enrollment:** Develop consistent methodology to be used for the selection of Clients appropriate for enrollment for the ACC Program and provide list of selected Clients.
2. **Data Repository:** Build, operate and maintain a data warehousing capability and capacity that integrates data from a variety of data sources, including claims data from the Department's Medicaid Management Information System (MMIS). Provide a scalable and open architecture which can interface with other systems in the future.
3. **Data Analytics and Reporting:** Provide sophisticated analytics on behalf of the Department, including, and not limited to: predictive modeling to create Member risk scores, performance monitoring and benchmarking, evaluating utilization variances, and creating provider profiles. This also includes building advanced reporting capabilities that will include both customized and a standard library of reports.
4. **Web Access:** Develop and host a Web Portal that provides reports and other information to designated stakeholders that includes ongoing help desk support for end-users.
5. **Accountability and Continuous Improvement:** Collaborate with other partners in the ACC Program to learn, improve, and identify and share best practices (nationally and within the ACC Program). Calculate cost data for the ACC Program, and identify areas with the largest cost saving potential.

The Department is the single agency responsible for the medical assistance programs, including Medicaid, the Children’s Basic Health Plan (marketed as the Child Health Plan Plus (CHP+), as well as a variety of other medical assistance programs for Colorado’s low-income and uninsured families, elderly and disabled persons. Together these medical assistance programs serve approximately 523,000 Colorado residents. Medicaid, the largest of the programs, provides health insurance for over 460,000 low-income residents, and the CHP+ program covers approximately 63,000 children and pregnant women. Currently, less than 15% of the 460,000 Medicaid Clients access their care through a managed care program. The remaining Clients access Medicaid covered services with providers that contract with the Department. The Department reimburses these providers through a Fee-For-Service (FFS) arrangement for each service provided such as an office visit, test, procedure, or other health care services. The Department also manages the Primary Care Case Management program in which primary care providers (PCPs) contract with the Department to serve as Primary Care Case Managers (PCCMs), responsible for delivering all routine preventive care and managing the care of those Medicaid Clients who choose to enroll. The program is called in the Primary Care Physicians Program (PCPP).

Three years ago, the State of Colorado embarked on a journey to improve Coloradans’ access to cost-effective, quality health care services. The Blue Ribbon Commission for Health Care Reform (the 208 Commission) assessed a variety of health care reform models in Colorado. After months of careful deliberation and discussion with stakeholders, constituents, legislators and executive officials, the 208 Commission presented a comprehensive report that provided a blueprint for health care reform in Colorado. Drawing upon the Commission’s recommendations, a series of legislative initiatives were proposed, referred to as the “Building Blocks to Health Care Reform.” During the 2008 legislative session, the legislature passed all of the initiatives. The new legislation expanded children’s health care coverage, increased reimbursement for providers, improved efficiencies in private and public health insurance programs, increased transparency and accountability across the health coverage system and identified further strategies to expand access to cost-effective, quality health care.

The Department began to implement the legislative initiatives contained in the Building Blocks to Health Care Reform and to make plans for additional reform strategies that had been identified. The Department was particularly interested in how to better contain health care costs while improving the overall health and functioning of the Clients we serve. We have learned over the years that higher health care spending is not necessarily associated with higher quality health care. Currently, the majority of our Medicaid Clients access their health care services in a service delivery model that does not always support coordinated care and the appropriate utilization of services. Clients often seek care in emergency rooms or other sites that offer episodic services. As a result, providers may not know the Clients’ history or ongoing health care needs. Since Clients interact with a host of Medicaid and non-Medicaid provider organizations ranging from schools and county government services to independent living centers and transportation vendors, access to and interaction between these providers and support organizations varies and little or no data is available to facilitate coordination of and continuity of care.

Two additional reform efforts were the Medicaid Value-Based Care Coordination Initiative (known as the ACC Program), and the “Colorado Health Care Affordability Act.” The Department worked simultaneously on these efforts. The Department submitted a formal budget

action for the ACC Program on November 3, 2008, and in April 2009 the Colorado Health Care Affordability Act (CO House Bill 09-1293) became law. Hailed as the State's most significant health reform in the past 40 years, the legislation authorizes the Department to generate revenue through a hospital provider fee and draw down federal matching funds. A portion of the fees will be used to provide coverage to additional uninsured Coloradans and make health care more affordable by reducing uncompensated care and cost shifting, without costing taxpayers or businesses more in taxes. Through this legislation, at least 100,000 more Coloradans will be eligible to apply for medical assistance programs over the next five years.

The passage of the Colorado Health Care Affordability Act, coupled with the unprecedented growth in Medicaid caseload because of the economic recession requires the Department to implement strategies that will both contain costs while improving health outcomes for our Clients. Additionally, with the passage of national health care reform, the Department recognizes that significant changes to the way health care services are delivered to our Medicaid Client is essential to maximize his or her health, functioning and independence.

In response to the changing health care environment, the Department plans to redesign the Medicaid program with the ACC Program serving as the foundation of its efforts. Through a separate solicitation, the Department will select contractors who will be accountable for controlling costs and improving the health of Medicaid Clients in one (or more) of seven regions statewide. These entities will be referred to as Regional Care Coordination Organizations (RCCOs). The RCCOs will meet the definition of a PCCM as defined by the Centers for Medicare and Medicaid Services and must meet the PCCM requirements set forth in 42 CFR 438. The ACC Program is a hybrid model, adding characteristics of a regional Accountable Care Organization to the Primary Care Case Management system.

The two central goals of the ACC Program are to improve health outcomes of Medicaid Clients through a coordinated, Client/family-centered system that proactively addresses Clients' health needs, whether simple or complex, and to control costs by reducing avoidable, duplicative, variable and inappropriate use of health care resources. To reach these goals, the Department will contract with RCCOs to focus on the following ACC Program objectives:

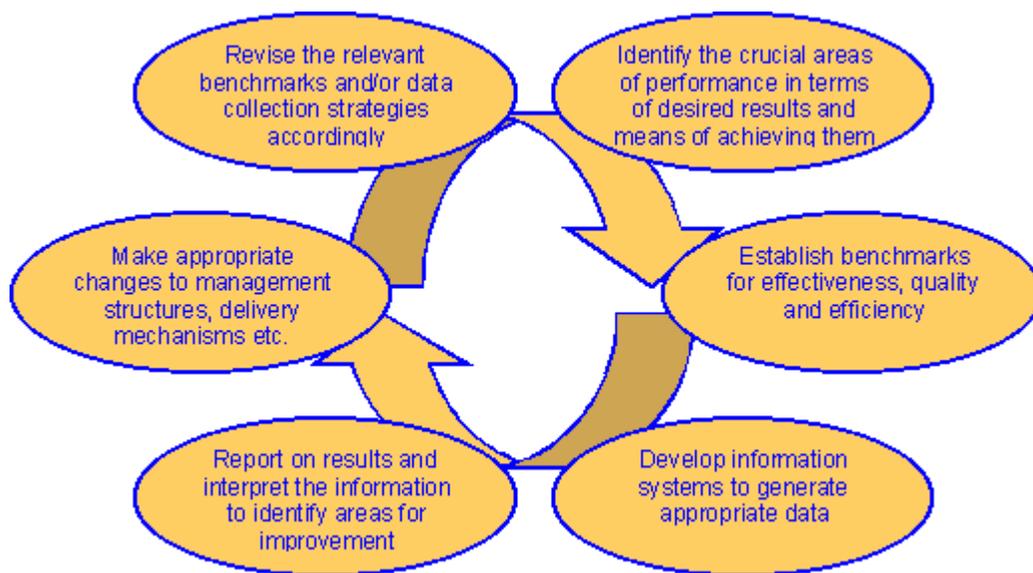
1. Expand access to comprehensive primary care;
2. Provide a focal point of care/Medical Home for all Members including coordinated and integrated access to other services;
3. Ensure a positive Member and provider experience and promote Member and provider engagement; and
4. Effectively apply an unprecedented level of statewide data and analytics functionality to support transparent, secure data-sharing and enable the near-real-time monitoring and measurement of health care costs and outcomes.

The ACC Program's design supports a paradigm shift from a volume-driven, FFS model to a coordinated outcomes-based system that will control costs in a responsible manner. At present, about 15% of Clients are enrolled in managed care programs; these programs will continue to be offered on a voluntary basis as well. The ACC Program is not designed to take the place of the Department's current managed care programs; rather, it is a new model for coordinating care that works within the FFS system. It will not assume direct management of any of the Department's

behavioral health care. Although RCCOs will need to work with the behavioral health managed care organizations to cooperatively manage individuals with mental and physical health comorbidities, responsibility for the provision of mental health services will remain with the behavioral health managed care organizations.

Building the infrastructure for the RCCOs is akin to building a car – all of the pieces need to fit together for it to function well. However, without sufficient or the right kind of fuel, the engine is likely to stall or not run at all. The SDAC will provide the fuel to power the engine of the RCCO. The SDAC will identify and recommend opportunities for improvement that are data and research driven, including peer learning between and within the RCCOs. The SDAC will assist the Department in the development of baseline performance measurements. The SDAC will provide the Department with operational information and tools to promote change and leverage the opportunities for improvement in a timely and meaningful way. Based on its analytics and reporting, the SDAC will assist the Department in the evaluation of the successes of individual providers within the RCCOs or with a specific RCCO. At the core of the ACC Program is reliable, timely information that supports care of our Clients, identifies proactive interventions for the population of a community and can trigger changes in the delivery of care.

The following diagram illustrates the performance improvement cycle that will be promoted through the implementation of the ACC Program by the SDAC, the RCCOs and the Department:



SECTION 2.0 ADMINISTRATIVE INFORMATION

2.1 ISSUING OFFICE

The Department's Contracts and Purchasing Section has issued this RFP, #HCPFKQ1103SDAC, on behalf of the State of Colorado for the benefit of the Medicaid Program Division and the Clients it serves. The Department's Contracts and Purchasing Section is the sole point of contact concerning this RFP. All inquiries must be directed to Katherine Quinby at the Department's Contracts and Purchasing Section, at katherine.quinby@state.co.us. See Paragraph A of the Administrative Information Document, published as Appendix A to this RFP, on inquiries. Please also see Section 2.4 of this document, Schedule of Activities and Timeline.

2.2 REQUEST FOR PROPOSALS

2.2.1 The Department's Contracts and Purchasing Section, State of Colorado is posting this RFP on the Colorado Bid Information and Distribution System (BIDS) website so that Offerors who have an interest may submit a proposal in accordance with the terms of this RFP. The RFP provides prospective Offerors with sufficient information to enable them to prepare and submit proposals for the Department to consider that ultimately meet the RFP requirements stated herein.

2.2.2 This RFP contains the instructions governing the proposals to be submitted and material to be included therein, mandatory requirements which must be met to be eligible for consideration, and other requirements to be met by each proposal submission. Appendix A to this RFP, Administrative Information Document, contains terms governing the solicitation and the solicitation process. The State of Colorado Solicitation Instructions and Terms and Conditions linked through the Colorado BIDS Solicitation Page govern, except as modified or supplemented in these instructions and the Administrative Information Document, Appendix A.

2.2.3 By submitting a proposal, the Offeror accepts the terms and requirements of this RFP without exception, deletion, qualification, contingency, condition or qualification. Any exception, deletion, qualification, contingency, condition or qualification by the Offeror may be cause for a proposal to be rejected. A proposal submitted in response to this RFP shall constitute a binding offer. Acknowledgement of the binding offer is indicated by signature on the Request for Proposal Signature Page, included in this RFP as Appendix B.

2.2.4 Modifications, addenda and responses to inquiries regarding this RFP will be posted on the Colorado BIDS website. It is the Offeror's responsibility to periodically check the website for information, changes or modifications that pertain to this solicitation.

2.3 PROPOSAL REQUIREMENTS

2.3.1 The Offeror's response must meet all requirements of and respond to all requests for information set forth in this RFP. Requests for information found in this RFP are

identified in Sections 4.0 and 5.0 in bold font. Requests for information regarding the price proposal are identified in Section 6.0. All requests for information must be addressed, with supporting detail and data as requested, in the Offeror's proposal. Section 6.0, Offeror's Response Format, contains submission details and additional requirements for the Technical and Price Proposals. Failure to respond to all requests for information and meet all requirements set forth in the RFP may result in the Offeror's disqualification.

- 2.3.2** The Offeror is required to submit one (1) hard copy original, clearly marked, nine (9) exact hard copies, clearly marked with the number of the copy, and an exact electronic copy on CD with each hard copy (a total of 10) of the Technical Proposal. In addition, the Offeror is required to submit in a separate binder one (1) hard copy original, clearly marked, nine (9) exact copies, clearly marked with the number of the copy, and an exact electronic copy on a separate CDs with each hard copy (a total of 10) of the Price Proposal. Electronic copies of both the Technical and the Price proposals on CD must be created with Microsoft Word or Excel, but may be submitted in Adobe PDF to ensure format integrity.
- 2.3.3** Each proposal shall describe a comprehensive, quality package of services and programs the Offeror agrees to provide, and demonstrate the Offeror's ability to serve as the SDAC and ACC Program partner with respect to all of the detailed questions and requirements posed in this RFP.

2.4 SCHEDULE OF ACTIVITIES AND TIMELINE

The following table summarizes the schedule of key activities for this RFP:

	ACTIVITY	TIME (MT)	DATE
1	RFP PUBLISHED ON BIDS WEB PAGE: www.gssa.state.co.us/VenSols		September 23, 2010
2	PROSPECTIVE OFFERORS WRITTEN INQUIRY DEADLINE – NO INQUIRIES WILL BE ACCEPTED AFTER THIS DATE. E-mail is the preferred method of inquiry. Send to katherine.quinby@state.co.us .	Noon	October 12, 2010
3	PUBLICATION OF DEPARTMENT'S ANSWERS TO WRITTEN INQUIRIES (<i>ESTIMATED</i>)		November 3, 2010
4	MANDATORY LETTER OF INTENT TO PROPOSE SUBMISSION DEADLINE		November 9, 2010
5	PROPOSAL SUBMISSION DEADLINE See Section 6.0 for submission details.	3:00 PM	November 30, 2010

	ACTIVITY	TIME (MT)	DATE
6	PROPOSAL SELECTION <i>Estimated the week of:</i>		January 3, 2011
7	CONTRACT FINALIZED <i>Estimated the week of:</i>		February 7, 2011
8	CONTRACT PERIOD: March 7, 2011 through June 30, 2013		

The Department reserves the right to revise the dates published in this schedule. Any such revisions will be made via modification to the RFP published on the Colorado BIDS Web site, except for items # 6 and #7. Dates for items #6 and #7 are estimates only and revisions will not be made by modification.

2.5 PERFORMANCE PERIOD

- 2.5.1 The anticipated initial term of the resulting contract for performance of SDAC services is **March 7, 2011**, or upon final execution of the contract, through June 30, 2013, contingent upon funds being appropriated, budgeted and otherwise made available.
- 2.5.2 The resulting contracts may be renewed for up to two additional one-year periods, at the sole discretion of the Department, contingent upon funds being appropriated, budgeted and otherwise made available, and other contractual requirements, if applicable, being satisfied.
- 2.5.3 Phases. The **SDAC** Start-Up Phase extends from the contract execution date through **June 30, 2011**. The **SDAC** Initial Phase extends from **July 1, 2011** through June 30, 2012 and the **SDAC** Expansion Phase extends from July 1, 2012 through June 30, 2013. Section 5.1.2 describes the phased approach to implementation in greater detail.

2.6 FUNDING

- 2.6.1 The funding for State Fiscal Year 2010-11 is available. Financial obligations of the State payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted and otherwise made available. The resulting contracts are subject to and contingent upon the continuing availability of federal, and state funds for the purpose hereof.
- 2.6.2 The Offeror recognizes that it is to be paid, reimbursed or otherwise compensated with funds provided to the Department by the state and federal governments for the purpose of contracting for the services provided herein. The Offeror expressly understands and

agrees that all its rights, demands and claims to compensation resulting under the resulting contracts are contingent upon receipt of such funds by the Department. In the event that the Department does not receive such funds or any part thereof, the Department may immediately terminate the resulting contracts without liability, including liability for termination cost.

2.6.3 The funding available for the SDAC for the remainder of State Fiscal Year 2010-11 is \$750,000. The expected budget amount for the SDAC for the State Fiscal Years 2011-12, 2012-13, 2013-14 and 2014-15 is \$3,000,000 for each fiscal year. If the total price proposed exceeds the funding available for State Fiscal Year 2010-11 or the expected budget amount any fiscal year, the proposal shall be disqualified.

2.7 DISCLAIMER

All statistical and fiscal information contained within this RFP, and any amendments and modifications thereto, reflect the best and most accurate information available to the Department at the time of RFP preparation. No inaccuracies in such data shall constitute a basis for legal recovery of damages or protests, either real or punitive, except to the extent that any such inaccuracy was a result of intentional misrepresentation by the Department.

2.8 MANDATORY LETTER OF INTENT TO PROPOSE

Offerors are required to submit a letter of intent to submit a proposal by close of business on Tuesday, November 9, 2010. The letter of intent to propose shall be on official business letterhead of the Offeror and must be signed by an individual authorized to commit the Offeror to the proposal. It is required to include the RFP Number, the Offeror's name, mailing address, electronic mail address, fax number, telephone number, a statement of intent to submit a proposal pursuant to this RFP, and be signed by an authorized individual. The Letter of Intent to Propose may be sent by mail, e-mail, or fax to the Department contact provided below.

Send to:

Katherine Quinby
State of Colorado
Department of Health Care Policy and Financing
Contracts and Purchasing Section
1570 Grant Street
Denver, CO 80203

Email: katherine.quinby@state.co.us

FAX No.: (303) 866-2422

If the letter is provided via email, please place the following in the subject line of your email: "Letter of Intent to Propose for RFP # HCPFKQ1103SDAC." Faxes should be addressed to the attention of Katherine Quinby. Please place the following in the subject line on your fax and attached letter of intent: "Letter of Intent to Propose for RFP # HCPFKQ1103SDAC." The Department may reject the proposal of any Offeror that fails to submit a Letter of Intent to Propose by the deadline specified. Submitting a Letter of Intent to Propose does not bind the

Offeror to submit a proposal.

2.9 LIMITED DATA SET OF MEDICAID CLAIMS DATA

2.9.1 The Department is making available a set of Medicaid claims data for Fiscal Years 2007, 2008 and 2009 to Offerors that submit a Letter of Intent to Propose. **Up to three sets of data discs will be made available to an Offeror to accommodate preparation of the proposal. The Offeror will be responsible for all sets of data discs provided.**

2.9.2 Offerors that have submitted a timely Letter of Intent to Propose may request, in writing or via e-mail, a CD containing the limited data set described below. Such requests should be sent, if emailed, to Katherine Quinby at katherine.quinby@state.co.us; or, if sent by letter, to Katherine Quinby at the same address as for submittal of the Letter of Intent to Propose.

2.9.3 The email or letter should state that you wish to receive a set of CDs with the limited data set of Medicaid claims data and the name and address of the custodian of the CDs for the Offeror. Specify ~~state~~ whether you wish the CDs ~~send~~ **to be sent** by US Mail, overnight services or ~~will~~ **to be** picked up. There will be no charge for the CDs and to have the CD mailed via US Mail. If delivery is requested via express delivery, the requester must provide an account number for the express shipment, or arrange for prepayment in some other fashion.

2.9.4 A confidentiality agreement executed by an authorized representative of the Offeror will be required prior to the CDs being provided. Copies of the confidentiality agreement may be requested from Katherine Quinby **immediately after the posting on BIDS of Modification No. 1-of-the-responses-to-inquiries.**

2.9.5 The sole purpose of the limited data set is to provide information to Offerors on Colorado Medicaid, its claims and eligibility groups, and the costs associated with them. Offerors are not permitted to copy the data or use it for any other purpose.

2.9.6 This is a limited data set under HIPAA; there is Client-level data but no actual Client identifiers, with the exception of a masked ID number for matching claims to Clients. The data set is solely for the use of the Offeror, and may only be used to inform the response to this RFP. The data includes:

1. FFS diagnosis codes
2. FFS procedure codes
3. Client eligibility category
4. County of residence
5. Client race, age and gender
6. Claim type (inpatient, outpatient, transportation, physician service, etc.)
7. Provider type
8. Drug type (for pharmacy claims)

For more information, see Appendix C, Client Data.

2.9.7 The original CDs must be returned together with the proposal, or, if a proposal is not being submitted, by the due date and time for the proposal. The proposal shall be disqualified and will not be evaluated or considered for award if an Offeror which has received the CDs does not return the original CDs with the proposal.

2.10 CONFLICTS OF INTEREST

Offerors are cautioned that the RCCOs and the SDAC must not be affiliated in any way due to the roles that each will serve for the ACC Program. If an Offeror submitted a proposal in response to RFP # HCPFKQ1102RCCO, Regional Care Collaborative Organizations for the Accountable Care Collaborative Program, there will be a conflict of interest for this RFP. Any proposal submitted for this SDAC RFP shall be disqualified if the Offeror or affiliated entity submitted a proposal in response to the RCCO RFP.

2.11 DRAFT CONTRACT

The contract resulting from this RFP will be substantively similar to the draft contract included with this RFP as Appendix D. The terms of the draft contract may become contractual obligations following award of this RFP.

2.12 DEBARMENT AND SUSPENSION

2.12.1 By submitting a proposal in response to this RFP, the Offeror certifies to the best of its knowledge and belief that it, its principals and proposed Subcontractors:

2.12.1.1 Are not presently debarred, suspended, proposed for disbarment, declared ineligible, or voluntarily excluded from covered transactions.

2.12.1.2 Have not within a three year period preceding the proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.

2.12.1.3 Are not presently under investigation for, indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in this section.

2.12.1.4 Have not within a three year period preceding this application had one or more public transactions (federal, state, or local) terminated for cause or default.

2.12.2 If the Offeror is unable to certify to any of the statements in this section, provide an explanation as an attachment to the Price Proposal. This explanation is exempt from page limitations on the Price Proposal, if any. The inability of the Offeror to provide the

certification will not necessarily result in disqualification of the Offeror. The explanation will be considered in connection with the Department's determination whether to award a contract to the Offeror.

2.13 VENDOR IDENTIFICATION

The tax identification number provided on the RFP Signature Page (Appendix B) must be that of the legal entity submitting the proposal to the RFP. The Offeror must be a legal entity with the legal right to contract. The Offeror that submits the proposal must be the legal entity that will perform the services described in the RFP. The Offeror must be registered on BIDS **by the due date and time for proposals**. If the Offeror is not registered on BIDS **at the due date and time for proposals**, the proposal shall be disqualified. **The successful Offeror must be registered with the Colorado Secretary of State to do business in the state by the execution of the contract.**

2.14 TERMINOLOGY

Acronyms are defined at their first occurrence in this RFP. A list of terminology and definitions is provided to assist the reader in understanding language used throughout the document. A complete glossary of terms and abbreviations used in this RFP is included in Appendix E.

The word "Member" is used throughout this RFP to refer to a Medicaid Client who is enrolled in the ACC Program. The term "Client" refers to an individual eligible for and enrolled in the Colorado Medicaid program, whether or not he/she is enrolled with a RCCO in the ACC Program.

2.15 RFP ORGANIZATION

The remainder of this RFP is organized as follows:

- SECTION 3.0 Background and Overview:** This Section provides an overview of the relevant programs administered by the Department as well as other relevant information that may be useful for the Offeror in preparing its proposal.
- SECTION 4.0 General Requirements:** This Section describes the general requirements that the Contractor will be expected to meet in performing the Scope of Work. General requirements include such information as mandatory minimums, experience and key personnel.
- SECTION 5.0 Statement of Work:** This Section describes the work required of the Contractor under the contract.
- SECTION 6.0 Offeror's Response Format:** This Section outlines the requirements for the Offeror's proposal.
- SECTION 7.0 Proposal Evaluation:** This Section provides an overview of the evaluation methodology and criteria that will be used to evaluate proposals.

APPENDICES: Provided to support information presented in the RFP.

SECTION 3.0 PROGRAM BACKGROUND, OVERVIEW AND AUTHORITY

3.1 DEPARTMENT PROGRAMS

3.1.1 Medicaid and the Children’s Basic Health Plan

The Department is the single State agency responsible for the medical assistance programs, including Medicaid, the Children’s Basic Health Plan (marketed as CHP+), as well as a variety of other medical assistance programs for Colorado’s low-income and uninsured families, elderly and disabled persons. Together these medical assistance programs serve approximately 523,000 Colorado residents. Medicaid, the largest of the programs, provides health insurance for over 460,000 low-income residents, while the CHP+ program covers approximately 63,000 children and pregnant women.

Medicaid is funded jointly by a state-federal partnership that finances health care coverage to primarily low-income populations and other designated groups of individuals. By statute, the Department performs the following functions:

- Oversees the administration of eligibility and enrollment services for medical assistance programs;
- Establishes the schedule of benefits, rules and cost-sharing structures;
- Manages administrative and health-related services contractors;
- Conducts program evaluation and development;
- Coordinates with other public and private health care delivery and financing programs; and
- Assures compliance with all related federal and state laws and regulations.

Family Medicaid covers children through the age of 18 up to 133% of the Federal Poverty Level (FPL) and parents with dependent children up to 100% of the FPL. Adult Medicaid encompasses many categories, including those receiving Supplemental Security Income (SSI). Colorado is a “1634 State” and therefore, the Social Security Administration is the only entity that determines disability eligibility for these disabled individuals. Colorado has expanded Medicaid coverage through several waivers to increase home and community based services. It does not administer a Medically Needy program (with less extensive eligibility criteria) nor has it expanded coverage to non-traditional Medicaid populations through a demonstration waiver under Section 1115 of the Social Security Act (Section 1115 waiver).

The Department administers CHP+ as a stand-alone program under the provisions of the Children’s Health Insurance Program (CHIP) administered by the Centers for Medicare and Medicaid Services (CMS). CHP+ is a state-federal partnership and finances health care insurance to low-income children and pregnant women who are not eligible for Medicaid. CHP+ covers children through the age of 18 and pregnant women age 19 and older residing in Colorado, with families having incomes at or below 250% of the FPL.

The Department has summarized health information for its population that shows patterns of illness, risky behaviors, and morbidity data for its clients. See Appendix F, Utilization and Cost Variance Maps for this information

3.1.2 Colorado Indigent Care Program

In addition to the Medicaid and CHP+ programs, the Department administers the Colorado Indigent Care Program, which distributes federal and state funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding deliver discounted health care services to Colorado residents, migrant workers and legal immigrants who have limited financial resources and are uninsured or underinsured and not eligible for benefits under the Medicaid or CHP+.

The Colorado Indigent Care Program is not health insurance and is analogous to a provider administered charity discount. Services are restricted to participating hospitals and clinics throughout the state. Medical services vary by participating health care provider. The responsible physician or health care provider determines what services will be covered. These services must include emergency care; and may include, but are not limited to, inpatient care, outpatient care and prescription drugs.

3.2 DEPARTMENT INFORMATION TECHNOLOGY SYSTEMS

3.2.1 Colorado Benefits Management System (CBMS)

Colorado Benefits Management System (CBMS) is an information technology system managed by the Colorado Governor's Office of Information Technology for the Department and the Colorado Department of Human Services. CBMS replaced six data collection systems with one unified system for data collection and eligibility determination. Through the utilization of a rules engine, the CBMS system determines eligibility of applicants for the Medicaid and CHP+ programs. In addition, the system establishes eligibility and benefits (for example, the amount of food and cash assistance available to a Client) for financial assistance programs administered by CDHS. After application data are entered by technicians (at the county and state level), the system simultaneously calculates the applicant's potential eligibility for the Medicaid and CHP+ programs.

3.2.2 Medicaid Management Information System

The Department has an automated claim processing system and information retrieval system for the management of Medicaid claims, the Medicaid Management Information System (MMIS). The MMIS operates in a client server environment with the server operating similarly to a mainframe and provides data to a decision support system. Colorado also has a point of sale pharmacy system that interfaces with the MMIS. The MMIS contractor (Medicaid fiscal agent) is Affiliated Computer Services, Inc. of Atlanta, Georgia, which maintains the system. See Appendix C, Client Data, for a partial list of MMIS data elements.

3.2.3 Provider Web Portal

The Provider Web Portal is a Web-based application that was developed by the Department and the current contractor, CGI Federal, Inc., and became operational in October 2003. It is built in Microsoft Visual Studio, with several technology add-ons to provide enhanced functional capabilities. The Provider Web Portal currently also links providers to the Department's Benefits Utilization System that provides case management documentation for HCBS Clients and to the federal system for the Systematic Alien Verification for Entitlement Program, an inter-governmental initiative designed to aid benefit-granting agencies in determining an applicant's immigration status.

The Provider Web Portal enables Medicaid providers and certain other entities to electronically send and receive secure transactions by Health Insurance Portability and Accountability Act (HIPAA) standards, and non-standard transactions to MMIS. Transmissions include the submission of claims for processing and payment, submission of requests for eligibility verification, and submission of requests for prior authorizations. The Provider Web Portal also enables users to manage their claims and pull various standardized reports, structure code sets for efficient data entry of claims, and update and maintain their MMIS Provider or Trading Partner information. The Provider Web Portal also affords the Department the ability to post messages concerning events that may impact Web Portal users.

3.2.4 Decision Support Systems

The Department's Decision Support System data warehouse provides information retrieval and reporting tools that support research, planning, monitoring, and evaluation of the Colorado medical assistance programs' operation and performance. This data warehouse contains a set of Oracle® databases, which include MMIS claims data, as well as reference, provider, Client, and prior authorization data. These databases are updated on a weekly basis from the MMIS relational database management system. Selected data are extracted from this relational database and loaded into the data warehouse to provide the Department with easy-to-use query, data transfer, and ad-hoc reporting capabilities. Authorized users utilize the Cognos® business intelligence information retrieval and reporting tools. The Department's MMIS contractor grants access to the data warehouse for a limited number of Department authorized contractors.

The main data warehouse tables include: Client; provider; claims header and line; prior authorization; and reference. The format for these tables is provided in Appendix C, Client Data. The Department's MMIS contractor hosts the data warehouse. The Department's connection to the data warehouse is currently through a virtual private network dedicated T1 with 1.5 Mbps data transfer rate. The Department is exploring upgrading this access to a 5 Mbps data transfer rate. The Department's long haul network consists of a dedicated T1 connection between the MMIS contractor and the Colorado Multi-Use Network core, which resides with the Office of Information Technology. The Department's Multi-Use Network connection is Gigabit Ethernet. The Ethernet (100M) side of the 1600 connects to the Core router known as R3 Router Cap (open).

3.3 OTHER DEPARTMENT INITIATIVES

3.3.1 Health Care Affordability Act (Colorado House Bill 09-1293)

On April 21, 2009, Colorado House Bill 09-1293, the Health Care Affordability Act, became law. This legislation authorizes the Department to assess and collect a provider fee from hospitals to generate additional federal Medicaid matching funds to improve reimbursement rates for inpatient and outpatient hospital services provided through Medicaid and the Colorado Indigent Care Program, and to expand health care coverage to more than 100,000 Coloradans over the next five years.

The Act established the Hospital Provider Fee Oversight and Advisory Board, which is responsible for working with the Department and the Medical Services Board to develop the Hospital Provider Fee Model, monitor the implementation of the bill, help with preparation of annual reports, and ensure that the Medicaid and CHP+ eligibility population expansions are implemented on schedule. The Hospital Provider Fee Model is a balance between the provider fee collected from hospitals, additional payments to Medicaid hospital providers, and the funds needed to cover the eligibility population expansions.

Additional information on the Hospital Provider Fee Oversight and Advisory Board and the Hospital Provider Fee Model is available at the Department's Web site www.colorado.gov/hcpf

As a result of receiving approval of the Hospital Provider Fee Model and fee assessment, the Department expanded Medicaid coverage to parents from 60% of the FPL to 100% of the FPL and CHP+ coverage from 205% of the FPL to 250% of the FPL in May 2010.

Scheduled to begin in the summer of 2011, a program expansion will allow people who have a disability to receive Medicaid by paying a monthly premium (Buy-In program). The Buy-In program will be implemented to provide medical benefits to children with disabilities whose family income is at or below 450% of the FPL, working adults, and nonworking adults with disabilities whose income is at or below 450% of the FPL. The eligibility standards, application processing, provider network and medical benefits to be offered have not yet been determined as of the posting of this RFP. The Department's estimated caseload for this eligibility population expansion is approximately 9,000 Clients.

Scheduled to begin in early 2012, the Department will offer medical benefits to low-income adults without dependent children or adults without Medicaid-eligible dependent children living in the household. The Department refers to this eligibility population expansion as Adults without Dependent Children. The Department anticipates that this expansion will be implemented through a Section 1115 waiver, state plan amendment, or other options allowed under the Federal Affordable Care Act. This expansion will allow adults without dependent children with incomes up to 100% of the FPL to qualify for a State-administered medical assistance program. The eligibility standards, application processing, provider network, and benefits offered have not yet been determined as of the posting of this RFP. The Department's estimate of the caseload for this eligibility population expansion is approximately 82,000 Clients.

The Department expects that these expansion populations will be integrated into the ACC Program.

3.3.2 Center for Improving Value in Health Care

The Center for Improving Value in Health Care was established by [Executive Order D 005 08](#), signed by Colorado’s Governor on February 13, 2008. The Center was created to establish an interdisciplinary, multi-stakeholder entity to identify and pursue strategies for quality improvement and cost containment. The Center’s overall goals are to develop recommendations to identify, implement, and evaluate quality improvement strategies to ensure a better value for the health care received in Colorado. Specifically, its goals are as follows:

- Create delivery systems that are consumer-centered and provide Coloradans with the tools needed to live healthy lives;
- Improve the health of Coloradans and the quality of health care received;
- Sustainably contain rising health care costs and lower premiums; and
- Enhance transparency in the health care market.

Strategies articulated by CIVHC include:

- Work with consumers to create meaningful information, tools and support so that they can become active participants in their health care, make informed decisions and utilize the health care system wisely;
- Provide transparent and comparative data on the cost and quality of health care services to consumers, providers, health plans, employers and policy makers;
- Change the incentives of current fee-for-service payment system in order to achieve high quality, consumer-centered and cost-effective care;
- Improve the way health care is delivered through increased access to appropriate levels of care and increased communication and coordination among providers; and
- Partner with businesses to leverage their influence to change Colorado's health care system, while providing them with tools to support their employees in proactively engaging in their own health care and well-being.

Colorado is among several states that is exploring how to create an all-payer claims databases to assemble and store medical, pharmacy and dental claims from health plans, third-party administrators (such as companies that process health claims for employers), Medicaid and Medicare. Such databases provide a complete picture of a person’s experience with the health care system. In Colorado, an advisory committee has been created to recommend how to structure and implement an all-payer claims database. When sufficient state and federal funds are appropriated, the all-payer claims database will become operational in Colorado.

3.3.3 Colorado Regional Health Information Organization (CORHIO)

Under [Executive Order D 008 09](#), CORHIO was designated by the Governor as Colorado’s “qualified State-designated entity” to lead the effort to expand the use of health information across Colorado to meet state and federal goals for improving health and health care delivery. In

October 2009, CORHIO released the Colorado State Health Information Exchange Strategic Plan. That strategic plan may be found on the Web at <http://www.corhio.org/about.aspx>

Through its strategic plan, CORHIO also recognizes the importance of public health alerts and the eventual need to exchange more comprehensive public health data. As part of this effort, CORHIO is working with the Colorado Department of Public Health and Environment to interface with the Colorado Immunization Information System, the Master Patient Index and potentially twelve additional Registries. CORHIO is charged with assisting in the development of Health Information Exchange processes and workflows to allow for efficient, effective and secure use of data by health care providers and State agencies. To support these reform measures and improve health information technology in Colorado, the Department is working with stakeholders to support communities and individual health care providers interested in participating in the CORHIO health information exchange. This will help providers become better equipped to use technology to facilitate the exchange of health information. Under the Health Information Technology for Economic and Clinical Health Act of 2009, eligible health care professionals can qualify for Medicare and Medicaid incentive payments when they adopt certified electronic health record technology and meaningfully use it to improve the quality and safety of care, improve care coordination, engage Clients and families, promote public health, and promote the security of private health information.

3.3.4 ICD-9 and ICD-10

ICD (International Statistical Classifications of Diseases) codes are alphanumeric designations given to every diagnosis, description of symptoms and cause of death attributed to human beings. These classifications are developed, monitored and copyrighted by the World Health Organization. In the United States, the National Center for Health Statistics part of the Centers for Medicare and Medicaid Services oversees all changes and modifications to the ICD codes, in cooperation with the World Health Organization.

Most of the codes we see in the United States today are version 9, called ICD-9-CM codes. With few exceptions, patient billing paperwork contains both CPT (Current Procedural Terminology) codes to describe the service that was rendered for billing purposes, and ICD-9-CM codes to describe why that service was provided. Most death certificates filed since 1977 will have an ICD-9 code on them.

The most current list of codes in use internationally is ICD-10. This list was first used in the United States in 2007. Globally, most other countries in the world have implemented the ICD-10 codes. There are some major differences between the ICD-9 and ICD-10 code sets and most American providers have not yet upgraded to the ICD-10 system. ICD-11, the next major update, is projected to be ready in 2010, with expected implementation by 2015. While an exact implementation plan is not currently available, the Department notes that it will be ensuring that its current MMIS and data warehouse is able to store ICD-10 codes. These data will be provided to the SDAC once available. The SDAC should be prepared to accept both the ICD-10-CM and ICD-10-PCS formats.

As a HIPAA Covered Entity, the Department will be complying with the CMS HIPAA 5010 Transactions and Code Sets Rule (42 CFR Part 162) by January 2012. The Department is currently conducting a gap analysis of its systems to identify affected systems and operational

areas, as well as develop an implementation plan for both HIPAA 5010 and ICD-10. While an exact implementation plan is not currently available, the Department notes that it will be able to transact claims in HIPAA 5010 formats while ensuring that its current MMIS and DSS is able to store ICD-10 codes. MMIS claims in both the ICD-9 and ICD-10 formats will be provided to the SDAC once available. The SDAC should be prepared to accept both the ICD-10-CM and ICD-10-PCS formats. Additionally, it will be required for the SDAC to accept and HL7 formatted transactions, which meet the HL7 (Health Level Seven) standards the exchange, integration, sharing, and retrieval of electronic health information.

3.4 ACCOUNTABLE CARE COLLABORATIVE PROGRAM

The ACC Program represents an innovative way to accomplish the Department's goals for Medicaid reform. The ACC Program differs from a capitated managed care program by investing directly in community infrastructure to support care teams and care coordination. It also creates aligned incentives to measurably improve Client health and reduce avoidable health care costs. The ACC Program makes the people and organizations that actually provide the care accountable for the health outcomes and cost of that care. Previous health care reform initiatives involved insurers and made them ultimately accountable. The fundamental premise of the ACC Program is that communities are in the best position to make the changes that will address the cost and quality problems resulting from our system of fragmented care, variation in practice patterns and volume-based payment systems. While the commitment and participation of providers will be essential to driving these changes, the supportive infrastructure that is necessary to make this paradigm shift is currently lacking. The ACC Program strengthens this infrastructure.

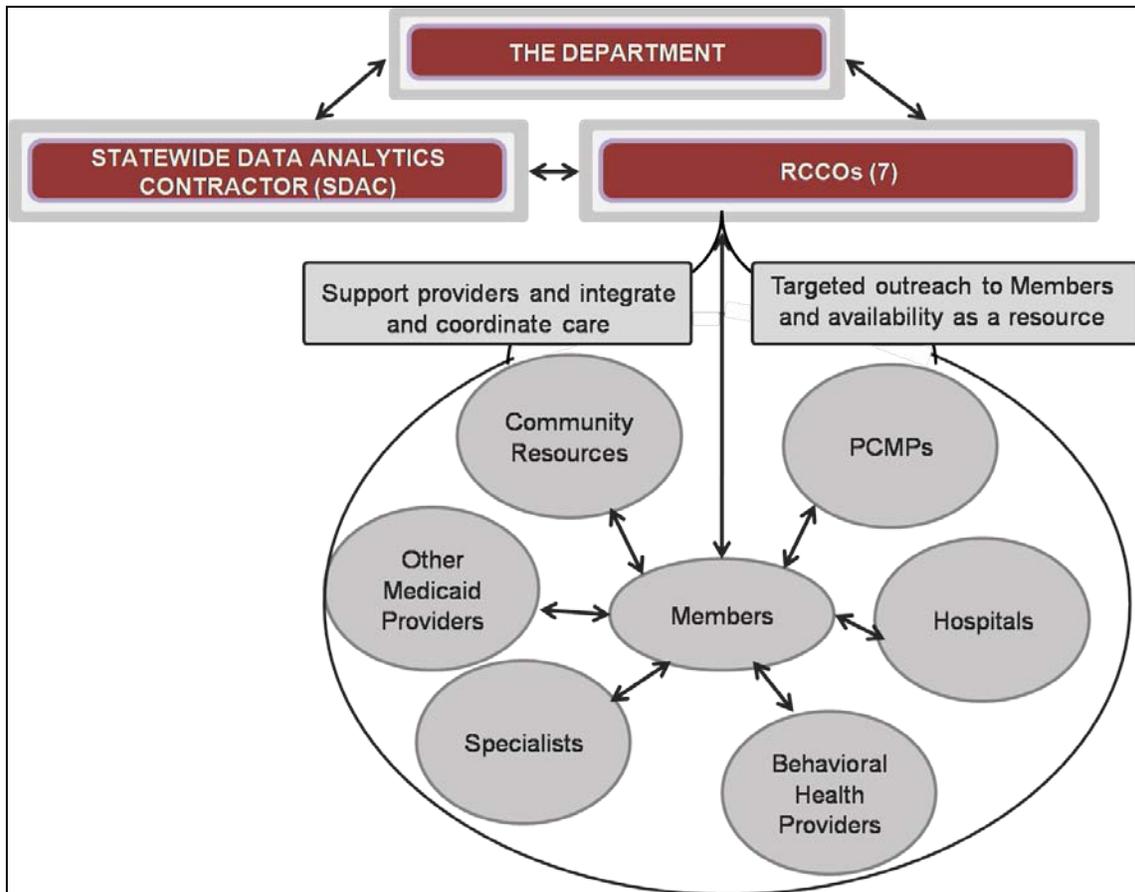
The ACC Program provides the framework within which other health care initiatives can thrive such as the Medical Home, health information technology, and payment reform. The ACC Program is a hybrid model, adding the characteristics of an Accountable Care Organization to the Primary Care Case Management system. While other states have structured their Accountable Care Organizations in a variety of ways, certain fundamental Accountable Care Organization characteristics are essential to the success of the ACC Program. These include managing and integrating the continuum of care across different settings, including primary care, inpatient care and post-acute care; having a large enough number of Clients to support comprehensive performance measurement; being capable of prospectively planning budget and resource needs; and having the ability to develop and organize provider networks.

3.4.1 ACC Program Design

The ACC Program is designed not only to improve the Client/family experience and improve access to care, but to establish accountability for cost management and health improvement. Central to the success of the ACC Program is the interaction among three key roles: the RCCOs, the SDAC, and Primary Care Medical Providers (PCMPs). The RCCOs are responsible for ensuring accountable care. The SDAC will be responsible for bringing a new level of information and data analytics to the Medicaid program, providing insight into variations within and across RCCOs, benchmarking across key performance indicators, and serving as conduit for health information exchange between the Department and the RCCO.

By integrating the principles of a Patient-Centered Medical Home model, applying best practices in care coordination and medical management, and combining unprecedented access to client data and resource utilization, RCCOs will become valued partners in the Department's efforts to move away from a focus on volume-driven, sick care and towards an outcomes-based, efficient, health improvement model of care. RCCOs will use both Patient-Centered Medical Home and accountable care principles, and their own expertise to help the Department control costs and improve health outcomes.

The diagram below reflects the general model and working relationships between the Department and these key roles.



At the foundation of the ACC Program design are several core elements that when combined and executed properly, will drive accountability and success in achieving improved health outcomes and managing costs. These core elements include a regional approach to managing, providing and coordinating care; the principles of the Patient-Centered Medical Home model; an integrated network of providers; the provision of high-quality care coordination and medical management services; an unrelenting focus on accountability to improve outcomes and control costs; analysis and application of informatics and benchmarking to review, measure and compare utilization, outcomes and costs; and a focus on continuous improvement and innovation, constant learning and sharing best practices.

3.4.1.1 Regional Approach

The design of the ACC Program focuses on regional collaboration that demands a constant focus on cost management and health improvement. Rather than having several competing entities within one region, the Department will award a contract to a single RCCO in each region, thus promoting collaboration within the region. This approach allows for collaboration among stakeholders, providers, Members, and other entities toward achieving results rather than marketing for membership. This regional approach promotes more comprehensive and coordinated care, encourages the RCCOs to leverage local relationships with and between providers and community-based organizations and to build upon existing regional systems of care. By managing Members on a regional basis and focusing on regional outcomes, performance and costs, the RCCOs and the Contractor will enhance Members' abilities to appropriately utilize the health system, offer providers consistent data and analysis to support care delivery, and enhance providers' efforts to deliver outcomes-based care. The regional approach also promotes the sharing of best practices.

3.4.1.2 Medical Home and Provider Network

The ACC Program builds upon the Patient-Centered Medical Home model and also incorporates additional elements to improve Member care and outcomes while supporting providers and protecting the safety net. Critical to the success of the ACC Program will be the PCMP. The PCMP is an individual provider or pod of providers that work closely as a team to serve as the Medical Home for the Member. Establishing a link between the Member and a PCMP who provides the majority of his/her care will be an essential function for the RCCO to facilitate.

Members will be assigned to a RCCO based on their residence address, may select a PCMP in another region and obtain care in other regions if they choose. RCCOs will assist their Members in selecting a PCMP who will deliver the majority of the Member's care.

Because Members have health needs that require access to a spectrum of care that differs by eligibility type, the Department envisions a system where each RCCO builds upon the existing Medicaid network according to strengths and opportunities within that region. See Appendix G, Eligibility Groups and Regional Caseload Overview, and Appendix H, Regional Overview of Selected Provider Types.

The Contractor will assist the RCCO in supporting the providers in its network administratively and operationally by highlighting those who engage in best practices and providing data and analytics to track the performance. Because most services outside the scope of the PCMPs will require referral, the Contractor may eventually support the RCCO by providing data that supports and tracks the referrals between providers in its network.

3.4.1.3 Medical Management and Care Coordination

Among the primary functions of the RCCOs will be care coordination and medical management, two key components often lacking in the FFS model. Generally, the current system of care is fragmented and difficult for Clients to navigate. Additionally, within the Medicaid population there is a prevalence of medically and behaviorally complex Clients

who require focused case management efforts and interventions to ensure that they are getting the right care, in the right order, at the right time, and in the right setting. Care coordination efforts extend beyond physical health to include efforts to link to resources available in behavioral health, long-term care, social services, criminal justice, and public health systems. The data and analytics provided by the Contractor will help the RCCOs to perform these important functions.

3.4.1.4 Accountability and Innovation

The goals of the ACC Program are to improve health outcomes and control health care costs. Successful performance in achieving these goals is expected from each RCCO. The Department encourages the Contractor to assist the RCCOs in being innovative and forward-thinking in their approach.

3.5 STATE AND FEDERAL AUTHORITY

The Department is the single state agency that operates the Colorado Medicaid program in accordance with the Colorado Medical Assistance Act (Section 25.5-1-101, *et seq.* C.R.S.) and Title XIX of the Social Security Act. The Colorado Medicaid program is annually funded from appropriations authorized by the Colorado General Assembly and matched by federal funds.

C.R.S. 25.5-5-402 Statewide Managed Care System requires the Department to adopt rules to implement a managed care system for Colorado under the state Medical Assistance Program (Medicaid). The Department has the authority for this program under Section 1932(a) of Title XIX of the Social Security Act.

SECTION 4.0 GENERAL REQUIREMENTS

This Section describes the general requirements that the contractor will be expected to meet in performing the Statement of Work. General requirements include such information as mandatory minimums, experience and key personnel as well as auditing, turnover, security and privacy requirements.

4.1 MANDATORY MINIMUM REQUIREMENTS

Each Offeror shall meet the requirements outlined in this Section. Offerors who are unable to demonstrate these requirements shall be disqualified. The Offeror **must have through its own organization or its subcontractors experience in the areas listed below. If the proposal includes the experience of a subcontractor to meet a mandatory minimum requirement, subcontractor must be proposed to perform services required by the RFP related to the experience.**

- 4.1.1 A minimum of five years, in the last seven years, of experience building, operating, and maintaining a data warehousing capability and capacity that integrates data from a variety of data sources, including experience providing a scalable and open architecture which has interfaced with other systems.
- 4.1.2 A minimum of five years, in the last seven years, of experience using sophisticated analytics for performance evaluation of complex programs.
- 4.1.3 A minimum of three years, in the last seven years, of experience developing and hosting a Web Portal that provides reports and other information to designated stakeholders that includes ongoing help desk support for end-users.

4.2 ADDITIONAL EXPERIENCE

- 4.2.1 The Department is seeking organizations with demonstrated success in building and operating a data warehouse, and turning data into usable information to identify opportunities for improvement and program planning. Offerors shall demonstrate experience providing data and analytics services for a business entity, enabling data-driven business decision-making, improving performance, and recommending best practices. The Offeror's experience should include:
 - 4.2.1.1 Experience in the health care industry to help a business entity achieve improved performance in health outcomes, cost management, and client and provider experience.
 - 4.2.1.2 Five years of experience, in the last seven years, managing health claims related data either in the private sector or working for government agencies that administer health care programs.
 - 4.2.1.3 Two years of experience, in the last seven years, identifying best practices and disseminating results to appropriate stakeholders as well as making recommendations that were implemented that contributed to the improved

performance of a particular program.

4.3 ORGANIZATIONAL STRUCTURE AND SUBCONTRACTING

The Offeror shall possess the corporate resources and structure necessary to perform as the SDAC and successfully implement and operate the statewide data and analytics activities under the ACC Program.

The Offeror shall have an internal organizational structure of sufficient size to perform, or direct the performance of, the services described in this RFP. The organizational structure shall clearly define lines of responsibility, authority, communication and coordination within and between various program components and activities.

The Offeror shall be solely responsible for all of the work performed under the contract resulting from this RFP, regardless of whether Subcontractors are used. The Department shall work solely with the Offeror with respect to all services to be performed under this contract. The Offeror shall have written subcontracts with all Subcontractors which shall require the same standards for performance as the Offeror. Subcontracted work shall not collectively exceed 50% of the **base contract work which does not include the ad hoc consulting project pool hours**. The Contractor shall report annually to the Department on its use of subcontractors. Nothing contained within this RFP or the resulting contract shall create any contractual relationship between any subcontractor and the Department. All subcontracts require the approval of the Department prior to start of work by a subcontractor.

4.4 PROFESSIONAL STAFFING REQUIREMENTS

The Department reserves the right to require the removal and replacement of any contractor employee or subcontractor employee found to be unacceptable to the Department or if it is otherwise determined to be in the best interest of the Department.

4.4.1 Key Personnel

The Offeror shall employ, at a minimum, the permanent staff described below. These key personnel must be employed by the Contractor and will need to be available in Colorado as directed by the Department for key meetings. Key personnel that the Offeror proposes shall serve in the positions for which they are proposed. Any new key personnel appointed during contract performance period shall have at least the same qualifications as the individual proposed for that position in the Offeror's proposal. The Department reserves the right to approve the key personnel prior to being assigned to work on the contract. The Contractor shall have the following permanent staff:

4.4.1.1 Project Manager, or Similar Title

The Project Manager shall act as the primary point of contact for the Department for contract and performance issues and responsibilities, conduct day-to-day project management, and ensure high quality services. All communication between the Department and the contractor shall go through the primary point of contact. The Project Manager shall work out of an office in the Denver-metro area and must be a full-time employee of the contractor. The

Project Manager should have experience managing a project of similar size and scope, preferably in health care.

4.4.1.2 Operations Manager, or Similar Title

The Operations Manager shall have the primary responsibility for coordinating and executing the tasks needed to ensure operational performance throughout the contract term. The Operations Manager ensures that data analytics and reporting services are compliant with federal, state, HIPAA and other regulations, and the database and application architecture and integration. The Operations Manager must be a full-time employee of the contractor and be located in the Denver-metro area. The Operations Manager should have experience with database and business intelligence projects of similar size and scope.

4.4.2 Other Staff Functions

In addition to providing key personnel, the Contractor shall ensure the following functions are performed by qualified staff employed by the Contractor or a subcontractor:

4.4.2.1 Analytics Management

Analytics Management functions include the overall responsibility of performing some combination of accounting, finance, analytical, controls, business process, and information technology knowledge to assist the Department and RCCOs with analyzing and enhancing the quality, usability and availability of data. The core functions should focus on transforming data into reliable information to allow the RCCOs to make better decisions in their delivery of services to Members, to assist the RCCOs and the Department in improving and using financial and operations data to improve decision making and program performance.

4.4.2.2 Best Practices Management

These functions include using data and analytics to identify and disseminate best practices, and assist RCCOs with best practice adoption. It includes setting baselines and benchmarking performance across RCCOs, reviewing reports to continually assess the RCCO progress and needs, and recommending interventions to achieve the goals of the RCCOs and ACC Program. It is also expected to facilitate resolution of any issues arising out of the accuracy and reliability of information in reports submitted to the RCCOs and other ACC Program Participants.

4.4.2.3 End User Support and Technical Support Call Center

This function has overall responsibility for ensuring that end users (such as the Department, the RCCOs, and PCMPs) have access to the SDAC Web Portal, and working with the Operations Manager to fix problems with the SDAC Web Portal. This function is responsible for receiving incoming phone calls from Web Portal end users, responding to user needs and requests, and troubleshooting problems with access to the Web Portal.

4.4.2.4 Web Development

This function is responsible for developing and testing the SDAC Web Portal applications, with a design that ensures appropriate access while ensuring the protection of private health information.

4.4.2.5 Database Administration Management

The Database Administration Management functions include the overall oversight and responsibility for database development and operations along with data transmission and translation services and health information exchange activities and interactions. Database administration management activities will also include the development of standards and guidelines to guide the use and acquisition of software and to protect vulnerable information.

4.5 TRANSPARENCY, ACCOUNTABILITY, AND RESPONSIBILITY

- 4.5.1 The Department desires a significant level of transparency with respect to the services to be performed by the Contractor. The Contractor will partner with the Department to achieve the goals expressed in this RFP and is expected to be proactive in identifying problems or areas for improvement and communicating any issues or recommendations to the Department in a timely manner.
- 4.5.2 Contractor staff shall maintain a relationship with Department staff that is based on trust, confidentiality, objectivity and integrity. The Contractor shall work cooperatively with the Department, stakeholders, RCCOs, providers and the staff of other contractors as needed or required by the Department during the contract term.
- 4.5.3 The Department also desires maximum accountability from the Contractor. The Contractor will be responsible for acknowledging and assuming responsibility for its actions, products, decisions and standard operating procedures in performing the services described in this RFP.
- 4.5.4 The Contractor shall coordinate and prioritize all work for these projects to ensure that all deliverables and deadlines are met. The Contractor shall demonstrate knowledge of all tasks, work plans, deadlines, and dependencies across deliverables necessary to perform the services. The Contractor shall ensure subcontractor(s) are knowledgeable of all tasks, work plans, deadlines, and dependencies across projects as they relate to work assigned to subcontractor(s).
- 4.5.5 The software design, data architecture design, data reporting, and web portal user interface functionality described in this RFP will be subject to testing and final approval by the Department. The Contractor shall submit all reports, plans, and other deliverables to the Department for review and approval.

4.6 COMPLIANCE, PRIVACY, AND SECURITY

The following sections describe the compliance, privacy and security requirements that the Contractor is required to meet during the contract term:

4.6.1 Compliance with State and Federal Standards

The Contractor shall comply with all state and federal statutes, regulations and rules applicable to the services described in the Statement of Work in the RFP. The Contractor shall also assist the Department in meeting state and federal requirements for the Medicaid program, including operational compliance with legislation passed at the federal or state level.

4.6.2 Health Insurance Portability and Accountability Act (HIPAA) of 1996

The Contractor shall ensure that all federal regulations regarding standards for privacy, security, electronic health care transactions and individually identifiable health information, the privacy regulations found at 45 CFR 160, 162 and 164, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the American Recovery and Reinvestment Act of 2009 (ARRA)/HITECH Act (P.L. 111-005), are continuously met. The Contractor must comply with any future HIPAA requirements. The Contractor shall execute a HIPAA Business Associate agreement which is an addendum to the Draft Contract, in Appendix D. The Contractor shall maintain comprehensive confidentiality policies and procedures approved by the Department.

The Contractor shall control the use or disclosure of Protected Health Information (PHI) as required by the HIPAA Business Associate agreement or as required by law. No confidentiality requirements contained in this RFP shall negate or supersede the provisions of the HIPAA privacy requirements.

4.6.3 CyberSecurity

The Contractor shall ensure that its information technology systems and websites are maintained and operated in accordance with both state and federal regulations. The Contractor shall:

- 4.6.3.1** Comply with the Colorado Cyber Security Policies which are found at <http://www.colorado.gov/cs/Satellite/Cyber/CISO/1207820732279>. A Cyber Security Plan shall be submitted to the Department for review and approval within 60 days after the contract effective date.
- 4.6.3.2** Comply with all state security policies outlined in the Colorado Information Security Act (C.R.S. 24-37.5) and the Governor's Office of Information Technology (OIT) Security Plan.
- 4.6.3.3** Complete a risk based gap analysis and vulnerability assessment annually in coordination with the Department and OIT and submit the results as directed by the Department. As state security policies are adapted to meet emerging security threats, the Contractor shall meet new standards. New standards will not result in additional compensation if new systems or equipment are not needed and the only requirements to meet the standards involve configuration, policies, procedures, or other technical improvements.
- 4.6.3.4** Provide centralized logging and flow monitoring as follows:
 - 4.6.3.4.1 Provide active monitoring of all security devices that includes regular monitoring of alerts and defense mechanisms to ensure immediate response to any security threats is required;
 - 4.6.3.4.2 Maintain security logs that a minimum details failed login attempts, successful login attempts, and account lock-outs;
 - 4.6.3.4.3 Review logs daily for security events and incidents. The Contractor shall notify OIT and the Department immediately of any security incidents that involve any potential compromise, data loss, malware, or other critical security issue affecting confidentiality, integrity, or accessibility; and

4.6.3.4.4 Update OIT and the Department at least daily with the status of any security events in progress.

4.6.3.5 Manage the vulnerability of systems as follows:

4.6.3.5.1 Permit OIT to perform full network vulnerability scans, with systems administrator credentials provided by the contractor upon 24 hour notice;

4.6.3.5.2 Apply all security patches rated as critical by the Internet Society (ISOC) to production systems immediately;

4.6.3.5.3 Apply all security patches rated as high by ISOC to production systems within 5 business days;

4.6.3.5.4 Apply all security patches rated as medium or low by ISOC to production systems within 15 business days; and

4.6.3.5.5 Request any exception to applying security patches as demonstrated by other security controls that are in place to mitigate the risk to vulnerability to OIT.

4.6.3.6 Implement systems and application security measures as follows:

4.6.3.6.1 All backups of production systems must be encrypted according to encryption standards set by OIT. (e.g., backup tapes utilizing 256 bit AES encryption).

4.6.3.6.2 All drives, backup media, and other storage media must be handled and disposed according to standards set by OIT and the State of Colorado (defined in "Data Handling and Disposal" document in <http://www.colorado.gov/cs/Satellite/Cyber/CISO/1167928186414?rendermode=preview>)

4.6.3.6.3 All systems and equipment must be hardened according to industry best practices and the State of Colorado standards.

4.6.3.6.4 Unnecessary services must be disabled or removed.

4.6.3.6.5 Risky protocols must be removed if not necessary to the function of the system. If risky protocols must be used, sufficient controls must be in place to protect the system from threats.

4.6.3.6.6 Systems and installed programs must be patched.

4.6.3.6.7 Host-based file integrity monitoring is required on all critical systems.

4.6.3.6.8 All systems must have virus protection installed unless an exception is granted by OIT.

4.6.3.6.9 Real-time protection must be enabled.

4.6.3.6.10 A full system scan must be performed at least weekly.

4.6.3.7 Perform an annual self-assessment that addresses security controls identified in the Contractor's CyberSecurity Plan and submit the plan to OIT and the Department as specified by the Department.

4.7 TURNOVER REQUIREMENTS

Prior to the end of the contract or in the event the Contractor is terminated prior to the contract termination date, the Contractor shall provide assistance in turning over the contract responsibilities to the Department or its new contractor. The Department seeks a low-risk turnover that does not adversely affect Clients, the Department, the RCCOs, providers and other stakeholders. During turnover, the Contractor is responsible for maintaining adequate staffing to maintain the performance standards required by this contract through the end of the contract term. The Contractor shall provide the Department and/or its designee with all materials and information related to the ACC Program to ensure a smooth transition to the Department or its new contractor to ensure continuity of services.

The following sections describe the Contractor responsibilities and performance standards specific to turnover activities. The Contractor shall:

- 4.7.1** Designate a person with appropriate training to act as the transition coordinator at least six months prior to the end of the contract term at no additional cost to the Department. The transition coordinator shall interact closely with the Department and its new Contractor. The Department will designate a turnover lead and back-up to answer questions and work with the Contractor to resolve issues surrounding the turnover activities.
- 4.7.2** Develop and submit a turnover work plan to the Department for approval at least six months prior to the end of the contract term at no additional cost to the Department. The turnover work plan shall detail the approach to turnover and define tasks that must be accomplished to successfully complete the turnover of the data and to transition all services described in the RFP to the new Contractor. The turnover work plan shall include:
 - 4.7.2.1** The approach to turnover, including an outline and executive summary;
 - 4.7.2.2** Planned Contractor turnover activities including tasks and sub-tasks;
 - 4.7.2.3** Suggested turnover activities for the Department or its new contractor;
 - 4.7.2.4** A schedule of events for turnover, milestones, baseline and actual start and finish dates, and a task completion report related to the activities above;
 - 4.7.2.5** Planned staffing levels during turnover;
 - 4.7.2.6** A complete list of software, hardware and other operating materials (including licenses with detail as to version number, license number and expiration date, if any) used in performing the services; and
 - 4.7.2.7** Any additional content specified by the Department.
- 4.7.3** Develop and submit to the Department for review and approval a turnover resource requirements statement (Statement) at least six months prior to the end of the contract term at no additional costs to the Department that describes the resources that would be required by the Department or new contractor to assume responsibility for the data analytics and reporting services, including personnel and non-personnel resources such as required equipment, hardware and software, including an estimate of the cost.
- 4.7.4** Correct any issues or concerns the Department identifies prior to the turnover.

- 4.7.5 Transfer to the Department, all data files and contract-related documentation pertaining to the performance of services. All files and documentation shall be in a readable, convertible format, agreed upon by the Department, to ensure an efficient turnover of responsibilities to the new contractor. The Contractor shall provide to the Department or its new contractor, any other information requested by the Department that the Department determines is necessary to facilitate a smooth and successful turnover.
- 4.7.6 Transfer all software licensed to the Department or owned by the Department to a new contractor or the Department.
- 4.7.7 Provide the Department, in a format prescribed and approved by the Department the following reports:
- 4.7.7.1 A list of all reports generated for the Department;
 - 4.7.7.2 A list of all reports generated for each RCCO;
 - 4.7.7.3 A list of all reports generated for provider organizations; and
 - 4.7.7.4 All data transmission documentation.
 - 4.7.7.5 The documented results of each completed milestone of the turnover work plan.

OFFEROR'S RESPONSE:

The Offeror's Proposal shall address each of the requirements outlined above including:

- 1. For each of the mandatory minimum requirements, provide information on experience which clearly demonstrates that the Offeror meets the stated requirement.**
 - a. Describe in detail the Offeror's experience building, operating, and maintaining a data warehousing capability and capacity that integrates data from a variety of data sources, including experience providing a scalable and open architecture which has interfaced with other systems.**
 - b. Describe in detail the Offeror's experience using sophisticated analytics for performance evaluation of complex programs.**
 - c. Describe in detail the Offeror's experience developing and hosting a Web Portal that provides reports and other information to designated stakeholders that includes ongoing help desk support for end-users.**
- 2. Describe in detail the Offeror's experience in the health care industry, helping a business entity achieve improved performance in health outcomes, cost management, and client and provider experience.**
- 3. Describe in detail the Offeror's experience in managing health claims related data either in the private sector or working for government agencies that administer health care programs.**
- 4. Describe in detail the Offeror's experience identifying best practices and disseminating results to appropriate stakeholders as well as making**

recommendations that were implemented that contributed to the improved performance of a particular program.

5. For each project described in 1-4 above, include the following information:

- a. The name and location of the client and the number of years performing for the client.
- b. The nature of the project, including the data analytics and reporting requirements of the project and how the data analytics resulted in the improvement of program performance.
- c. Any corrective action plans entered into over the course of the project, or any findings related to contract non-compliance or deficient performance.
- d. Contact information for the client's project manager. If the services were not provided under contract with another entity, provide the contact information for an individual who can discuss project performance. Contact information shall include the person's name, title, phone number, and email address.

~~e. A list of three other key individuals, with contact information, willing to provide a reference regarding the abilities and performance of the Offeror, or, for a new organization, its key personnel.~~

6. Provide a detailed description of the Offeror's internal organization structure, including delineated management structure. An organizational chart shall be included with the description, showing the number and types of employees.
7. Provide the number of proposed staff by job title, a brief job description for each title, and evidence that the organization has a sufficient number of qualified staff to manage all requirements as described in this RFP. Propose personnel to fill each of the positions and functions described in Section 4.3 above. Include names, titles, résumés, and a description of relevant experience. **Résumés submitted in response to this requirement will not be counted against the 200-page limitation.**
8. Provide a detailed subcontracting plan if the Offeror plans to subcontract with other entities to perform portions of the Statement of Work, listing names and addresses of the Subcontractors to be used. Identify the Subcontractor's location(s), including any offices in Colorado. Describe the services that the Subcontractor will provide and an estimate of the percentage of the total Statement of Work to be performed by each Subcontractor. Provide the plan to oversee the Subcontractor to ensure quality performance. Describe the Offeror's experience managing Subcontractors.
9. Describe how the Offeror shall ensure the security of information held and shared by the SDAC. Offerors shall describe how they propose to manage complex data relationships that infer patient privacy/HIPPA concerns. Included in this response the Offer shall provide:
 - a. A proposal for the implementation of role-based security, in which a user is provided access based on his or her role;

SECTION 5.0 STATEMENT OF WORK

5.1 OVERVIEW

The Contractor is responsible for bringing a new level of information and data analytics to the Medicaid program. The Contractor will provide business intelligence insights to identify unexplained variation within and across RCCOs. It will also support benchmarking across key performance indicators and support collaborations to identify best practices to improve efficiency and effectiveness. The SDAC will be the conduit for health information exchange between the Department and the RCCOs to enable effective, Member-specific medical management, risk prediction, and risk management.

The ACC Program's performance is measured by controlling the costs of the Medicaid program and measurably improving the health of Members. The Department is purchasing performance from each RCCO and is purchasing statewide data, analytics and reporting from the SDAC to measure the performance of the RCCOs. Setting performance targets, measuring performance, and rewarding performance are essential to ensuring and maintaining accountability.

5.1.1 Core Services

The SDAC shall provide the following core services for the ACC Program as further described in this Section of the RFP as follows:

- 5.1.1.1 Client Selection for Program Enrollment:** Develop and implement a consistent methodology to replenish enrollment for the ACC Program during the SDAC Initial Phase and to expand enrollment during the SDAC Expansion Phase.
- 5.1.1.2 Data Repository:** Build, operate and maintain a data warehousing capability and capacity that integrates data from a variety of data sources, including claims data from the Department's Medicaid Management Information System (MMIS). Provide a scalable and open architecture which can interface with other systems in the future.
- 5.1.1.3 Data Analytics and Reporting:** Provide sophisticated analytics on behalf of the Department, including, and not limited to: predictive modeling to create Member risk scores, performance monitoring and benchmarking, evaluating utilization variances, and creating provider profiles. This also includes building advanced reporting capabilities that will include both customized and a standard library of reports.
- 5.1.1.4 Web Access:** Develop and host a Web Portal that provides reports and other information to designated stakeholders that includes ongoing help desk support for end-users.
- 5.1.1.5 Accountability and Continuous Improvement:** Collaborate with other partners in the ACC Program to learn, improve, and identify and share best practices (nationally and within the ACC Program). Calculate cost data for the ACC Program, and identify areas with the largest cost saving potential.

5.1.2 Phased Approach

The Department plans a phased approach to implementing the ACC Program to ensure a seamless and smooth process for the SDAC, RCCOs and Members. The three phases include the Start-Up Phase, the Initial Phase and the Expansion Phase. For the SDAC, the **SDAC** Start-Up Phase extends from contract execution through **June 30, 2011**. The table below is a brief summary of the activities that will take place during each phase. Each task is described in the section of the Statement of Work that addresses it.

PHASE	START DATE	END DATE	MILESTONES
SDAC Start-Up Phase	Contract Effective Date	6/30/2011	<ol style="list-style-type: none"> 1. Accept historical flat file of MMIS data. Provided to Contractor 2 weeks after contract effective date. 2. Submit Interim plan for Distribution of Data and Analytic Reports for approval. Due 30 days after contract effective date. 3. Submit comprehensive analytics and reporting plan for approval. Due 60 days after contract effective date. 4. Submit Client selection methodology to Department for approval. Due by May 1, 2011. 5. Collaborate with RCCOs and PCMPs to implement Interim plan reporting. Due by May 1, 2011.
SDAC Initial Phase	7/1/2011	6/30/2012	<ol style="list-style-type: none"> 1. Collaborate with the Medicaid fiscal agent to perform monthly uploads of selected clients for replenishment enrollment. 2. Generate monthly reports to show RCCO progress on a defined set of utilization measures. 3. Extract, transform and load three years of MMIS claims data into. Due by August 1, 2011. 4. Design, develop and test SDAC Web Portal. Due by October 1, 2011. 5. Support standard production reports for SDAC Data Repository and Web Portal. Due by October 1, 2011. 6. Provide to RCCOs and PCMPs access to the SDAC Web Portal, and ongoing Help Desk support. Due by December 1, 2011. 7. Integrate RCCO data into SDAC Data Repository. Report on progress due by

			<p>December 31, 2011.</p> <ol style="list-style-type: none"> 8. Calculate overall ACC Program cost savings. Due by June 15, 2012. 9. Establish methodologies for risk adjustment, predictive modeling, provider comparison, and performance measurement. 10. Identify and disseminate best practices.
SDAC Expansion Phase	7/1/2012	6/30/13	<ol style="list-style-type: none"> 1. Continue Client selection for enrollment, data analytics and reporting, and Web Portal access and support. 2. Integrate external sources of health status and clinical data into the SDAC Data Repository. Report due by July 30, 2012. 3. Establish methodologies for identifying regional variability, poor referral practices. 4. Calculate incentive payments for RCCOs and PCMPs. 5. Submit final ACC program cost savings calculation and report. Due by November 30, 2012.

5.2 CLIENT SELECTION FOR PROGRAM ENROLLMENT

The Department will maintain an enrollment of 60,000 Members, assigned evenly among the regions, in the ACC Program during the Initial Phase. The 60,000 Member cap will be reached over the course of five months (outlined in the table below). Once the enrollment cap is reached and as Clients lose Medicaid eligibility and are, therefore, no longer able to participate in the ACC Program, additional Clients will be enrolled as part of monthly enrollment replenishment in order to maintain a total of 60,000 Members. In the Expansion Phase the remaining clients not currently enrolled in a managed care program will be enrolled as Members in the ACC Program.

The Department anticipates that enrollment activities will need to occur prior to the execution of the contract with the Contractor, and therefore Departmental staff will select the clients for initial enrollment during the Start-Up Phase. The Contractor shall be responsible for identifying clients appropriate for enrollment replenishment on a monthly basis during the SDAC Initial Phase, being knowledgeable of the enrollment process and submitting client selection lists to the Medicaid fiscal agent based on a specified schedule. The Contractor shall develop a methodology that can be scaled statewide and be responsible for selecting Clients for enrollment and assigning them to a PCMP as the ACC Program enters the Expansion Phase.

5.2.1 Membership in the ACC Program

During the SDAC Initial Phase of operations, there will be 60,000 Members assigned evenly among the seven regions shown in Appendix I, or approximately 8,600 Members per region.

About one-third of the members in each region (2,900 in each region or 20,000 total Members statewide) will be Medicaid children who are currently part of the Medicaid and CHP+ Medical Homes for Children program. The remaining two-thirds will be drawn from the adult PCPP and FFS Medicaid populations in each region. Clients who are dually eligible (receive both Medicare and Medicaid), and Clients residing in state psychiatric institutions or long-term nursing facility placements will not be eligible for participation in the ACC Program during the **SDAC** Initial Phase.

Once in the **SDAC** Expansion Phase, the Department envisions that the majority of Medicaid Clients not currently enrolled in a managed care program will be enrolled as Members in the ACC Program. During the **SDAC** Expansion Phase, Membership will be open to all Medicaid eligibility groups, and regional Membership will grow from 60,000 members clustered in Focus Communities across the seven regions to approximately 500,000 members Statewide.

Because the **SDAC** Initial Phase of the ACC Program is limited to approximately 60,000 Members, each RCCO is expected to concentrate efforts on a core network of PCMPs and other Medicaid providers in Focus Communities. Focus Communities are those communities where the RCCO has identified excellent systems of care, there is an opportunity to promote best practices and reduce unnecessary variation in care, and there are especially strong connections between health providers and community resources.

5.2.2 Enrollment and Regional Rollout

Enrollment in the ACC Program will be on a voluntary basis only. Clients will have the choice to participate in the ACC Program or to “opt out” of participating in the program. Members will be enrolled using the voluntary process called Passive Enrollment. Passive Enrollment includes selecting Clients appropriate for enrollment, notifying those Clients that they will be enrolled unless they contact the Enrollment Broker to make another choice, and giving Clients time to make a decision.

The regions will be divided into two roll-out time frames: one with a “go-live” date of April 1, 2011 and the other with a “go-live” date of June 1, 2011. The following table identifies the region roll-out schedule, including the enrollment process start date and when the RCCO will begin serving Members (“go-live” date).

Monthly Cycle	Regions 1, 2 & 4	Monthly Cycle	Regions 3, 5, 6 & 7
Month 1 (February)	<ul style="list-style-type: none"> • The Department selects Clients for enrollment • Enrollment Broker mails 8,600 Client notices. 		
Month 2 (March)	<ul style="list-style-type: none"> • Month 1 Clients may opt out within 30 days. • Additional Client notices to 		

		meet 8,600 enrollments are sent.		
Month 3 (April)		<ul style="list-style-type: none"> Month 1 Clients that do not opt out are enrolled as Members. RCCO goes live – serves Members. Month 2 Clients may opt out within 30 days. Additional Client notices to meet 8,600 are sent. 	Month 1 (April)	<ul style="list-style-type: none"> The Department selects Clients for enrollment Enrollment Broker mails 8,600 Client notices.
Month 4 (May)		<ul style="list-style-type: none"> Replenish enrollment – as Members lose Medicaid eligibility, Client notices to maintain 8,600 are sent. 	Month 2 (May)	<ul style="list-style-type: none"> Month 1 Clients may opt out Additional Client notices to meet 8,600 enrollments are sent.
Months 5 + (June and monthly thereafter)		<ul style="list-style-type: none"> Replenish enrollment monthly. 	Month 3 (June)	<ul style="list-style-type: none"> Month 1 Clients that do not opt out are enrolled as Members. RCCO goes live – serves Members. Month 2 Clients may opt out within 30 days. Additional Client notices to meet 8,600 are sent.
			Month 4 (July)	<ul style="list-style-type: none"> Replenish enrollment – as Members lose Medicaid eligibility, Client notices to maintain 8,600 are sent.
			Months 5 + (August and monthly thereafter)	<ul style="list-style-type: none"> Replenish enrollment monthly.

5.2.3 Data Source

5.2.3.1 During the Start-Up Phase and during the Initial Phase until the SDAC Data Repository is operational, the Department will provide a flat file of three years of claims data for all Medicaid Clients for the purposes of creating the list of Clients appropriate for Membership. The Contractor shall use the flat file data to identify the populations described in Section 5.2.4.2.

5.2.3.2 Once the SDAC Data Repository is operational, the Department will provide weekly MMIS files for the Contractor to download and put into the SDAC Data Repository, as described in Section 5.3.5.1. The Contractor will use those weekly files for Member selection, as well as for the other purposes described elsewhere in this RFP.

5.2.4 Client Selection

The Contractor is responsible for selecting Clients appropriate for **replenishment and expansion** enrollment into the ACC Program, and assigning a PCMP to any Client that **has a historical relationship with a PCMP**. The Contractor shall complete the Client selection process two months prior to the date of actual enrollment based on the schedule described in the table above. The Contractor shall develop a methodology for client selection during the **SDAC Start-up** Phase, and submit it to the Department for approval. The methodology shall be guided by the following principles: keeping families together, allowing providers to have a concentration of Members in their practices. Selection should be random to the extent possible, not to select Members based on health status, eligibility category, or utilization patterns. The methodology shall be based on the guidance and steps identified below:

5.2.4.1 Establish provider and community base. For each region, using the list of contracted PCMPs and the counties included in the RCCO Focus Communities, determine the provider and community base from which clients can be selected.

5.2.4.2 Identify universe of clients for selection and separate by category. Using the established provider and community base, identify all clients appropriate for selection in the following four categories:

5.2.4.2.1 Children age 20 and under enrolled in the Medicaid and CHP+ Medical Homes for Children Program.

5.2.4.2.2 Adults over age 20 enrolled in the PCPP and assigned to a ACC PCMP.

5.2.4.2.3 Adults over age 20 in the FFS program (unassigned to a PCMP) that reside in the Focus Communities.

5.2.4.2.4 Adults over age 20 newly eligible for Medicaid and residing in the Focus Communities.

5.2.4.3 **PCMP** attribution to unassigned clients. Assign a PCMP to all adult Clients that are not yet assigned to a PCMP, by using claims history and an attribution methodology to determine which PCMP the Client has seen the most frequently in the past 12 months.

5.2.4.3.1 The Contractor may need to tailor the attribution methodology to the types of data the Department receives from different providers. ~~The claims data for Federally Qualified Health Centers received from the Federally Qualified Health Centers and Rural Health Clinics have only a single diagnosis code, while practice-based FFS providers may list up to ten diagnosis codes on their claims.~~

5.2.4.3.2 With the exception of the methodology adaption required for accommodating different types of claims data, the Contractor shall use a consistent methodology for Client attribution calculations and measurements, to prevent selection bias.

5.2.4.3.3 The Contractor shall submit the Client attribution methodology to the Department for review and approval before it is used to assign Members to PCMPs.

5.2.4.4 Selection of Clients from the universe of appropriate Clients. Select Clients to be enrolled, selecting randomly on health status and eligibility category. **If data is available, the Contractor shall consider** PCMP preferences for panel size and whether PCMPs prefer to have all their Medicaid Clients in the ACC program. The Client selection shall be broken out in the following way:

5.2.4.4.1 One third (approximately 2,900 per region) shall be children from the Medicaid and CHP+ Medical Homes for Children Program. The Contractor shall make every effort to place family members into the same RCCO.

5.2.4.4.2 Two thirds (approximately 5,700 per region) shall be adults clients residing in the Focus Communities from the PCPP or FFS programs or newly eligible for Medicaid.

5.2.5 Enrollment Process After Client Selection

5.2.5.1 During the **SDAC** Initial Phase, after selecting Clients **who replenish enrollment** into the ACC Program, the Contractor shall send the information (such as name, Medicaid ID, date of birth, PCMP, and region) for selected Clients to ACS, the Department's Medicaid fiscal agent, in a Microsoft Excel spreadsheet.

5.2.5.2 The following steps occur before information will be returned to the Contractor:

5.2.5.2.1 The Microsoft Excel Spreadsheet will be uploaded to a secure FTP site that is provided by the Department's Medicaid fiscal agent.

5.2.5.2.2 The Department's Medicaid fiscal agent will download the spreadsheet information into the MMIS. The Member's enrollment spans in the ACC Program will be generated in the MMIS. These enrollment spans will include the assigned RCCO and PCMP, for all Members with an assigned PCMP.

5.2.5.2.3 The MMIS will generate a notice file that is sent to the Department's Enrollment Broker. The Enrollment Broker will use that notice file to generate the passive enrollment letters to Clients. For Clients who desire to opt out of the ACC Program, the Clients will contact the Enrollment Broker directly which can cancel the Member's enrollment spans generated by the MMIS. The Enrollment Broker also has the authority to modify enrollment spans and assign a PCMP if requested by the Member. The SDAC will receive these updates in the next weekly data pull from MMIS.

5.2.5.2.4 The MMIS will generate an error notice file that is sent to the Contractor. The error notice file identifies individuals the Contractor selected for passive enrollment, but were not accepted by the MMIS. Possible reasons for non-acceptance include incorrect Client information, or the Client has recently been disenrolled from Medicaid.

5.2.5.3 Upon receiving the error notice file, the Contractor shall:

5.2.5.3.1 Use the information from the error notice file to select additional individuals to maintain the specified level of enrollment in the ACC Program.

5.2.5.4 Upload files to the secure FTP site weekly on a day to be established between the Contractor, Medicaid fiscal agent and Department.

5.2.5.5 By February 28, 2011, the Department will upload the 25,800 selected individuals to be enrolled in the first 3 RCCOs. ~~The Contractor will perform weekly uploads to maintain the Members at 25,800.~~ By April 30, 2011, the Department shall upload the 36,000 selected individuals to be enrolled in the next four RCCOs. The Contractor shall create monthly replenishment lists beginning in July 1, 2011 to maintain the Members at 60,000. In the Expansion Phase, the Contractor shall select an additional 41,000 clients per month for enrollment spread across the 7 regions to ensure all clients are enrolled within the first 12 months of the Expansion Phase.

5.2.5.6 For the SDAC Expansion Phase, the Contractor shall establish an electronic interface between the Contractor and the MMIS in coordination with the Medicaid fiscal agent and Department to eliminate the need to manually transfer Microsoft Excel Spreadsheet through the secure FTP site.

OFFEROR'S RESPONSE

The Offeror's proposal shall address each of the requirements outlined in Section 5.2 including:

- 1. Describe Offeror's approach for selecting Clients for Membership, and attribution methodology for assigning Members to a PCMP. Describe why the Offeror's approach is reasonable and appropriate for the Medicaid population.**
- 2. Provide a proposed schedule for meeting the timeline to support the RCCO enrollment. Describe Offeror's capabilities to meet the required timelines, any anticipated challenges to meet the timelines, and strategies to mitigate any delays in the process.**

5.3 DATA REPOSITORY

A comprehensive database that can hold all data relevant to the ACC Program is required in order for the Contractor to do the analytics necessary to guide the program. In the SDAC Initial Phase of the program, this data warehouse, called the SDAC Data Repository, will be populated with Medicaid claims data from the MMIS, and other data that the RCCOs will be collecting. As the program expands, the SDAC Data Repository will also include data that fills in missing clinical and health outcomes data for the Medicaid population, such as disease and immunization registries and national health survey data.

The Contractor shall provide the infrastructure to create, host and support all technical architecture required for data hosting, including the physical installation of necessary hardware, software, database and network components. The Contractor and the Department will work together to enable mutual system access for easy exchange of data between them. The Contractor shall oversee operations and perform maintenance on the SDAC Data Repository, and routinely

validate its data to ensure that the analytics and reports generated are done with accurate data. To further protect the data in the SDAC Data Repository, the Contractor shall develop plans for regular data back-up and system recovery in the event of a disaster.

5.3.1 System Build

The Contractor shall build the SDAC Data Repository to hold the required data. Specifically, the Contractor shall:

- 5.3.1.1** Build the necessary system architecture and infrastructure to host and support all components required for data hosting for the ACC Program. This includes the physical installation of necessary hardware, software, database and network components required for implementation of the technical architecture.
- 5.3.1.2** Design, develop and implement a data warehouse (SDAC Data Repository) sufficient to support the goals of the ACC Program and accommodate the data described in section 5.3.2, Populating the Data Repository.
- 5.3.1.3** Conduct a formal readiness walkthrough with the Department demonstrating the Contractor's implementation of the SDAC Data Repository, including Contractor's ability to extract, transform and load data, by August 1, 2011.

5.3.2 Populating the Data Repository

This section describes the data that goes into the SDAC Data Repository, and the activities required for loading the data into it. In the **SDAC** Initial Phase of the program, this data warehouse, called the SDAC Data Repository, will be populated with Medicaid claims data from the MMIS, and other data that the RCCOs will be collecting. As the program expands, the SDAC Data Repository will also include data that fills in missing clinical and health outcomes data for the Medicaid population, such as disease and immunization registries, national health survey data, and data available from the Colorado Regional Health Information Organization (CORHIO).

5.3.2.1 MMIS Claims Data

- 5.3.2.1.1** Upon the final execution of the contract with the Department shall provide three years of data from the Department's MMIS , using a Comma Separated Values file, for the Contractor to load into the SDAC Data Repository. Thereafter, the Department will generate a weekly MMIS data file and place it into a secure FTP site for the Contractor to download and put into the SDAC Data Repository.
- 5.3.2.1.2** The data includes Client eligibility and claims information, and also includes information on Medicaid enrolled providers. (See Appendix C, Client Data, for more information). The data will include claims for all Medicaid Clients, and will not be limited to claims for ACC Program Members. This will give the Contractor adequate data for setting baselines and benchmarks for performance during the **SDAC** Initial Phase, and will also give the Contractor data for all Medicaid Clients, most of whom will participate in the ACC Program in the **SDAC** Expansion Phase.

5.3.2.1.3 The Contractor shall have the capability to accept ICD-10 codes for all claims with dates of service on or after October 1, 2013. ICD-9 will be used for claims with dates of service through September 30, 2013. The Contractor must be able to store, query, analyze, trend, transmit, etc. the increased field size for both ICD-10 diagnoses and ICD-10 PCS (inpatient procedures) on October 1, 2013, and for the ICD-9 code and format as well

5.3.2.2 RCCO Data

The RCCOs are responsible for a variety of activities to support PCMPs and Members. As they do this work, the RCCOs will collect information that is relevant to the Contractor's analytics and reporting responsibilities.

5.3.2.2.1 The RCCOs will provide data on its formal and informal networks of providers. The Contractor shall load this information into the SDAC Data Repository.

5.3.2.2.2 The Contractor shall then work with the RCCOs to identify and capture pertinent data, store it in the Data Repository, and integrate it into analytics activities. This will include data such as Member care coordination and medical management activities, referrals to non-medical services, translation or cultural needs of Members, and non-medical services utilized by Members. The Contractor shall work with the RCCOs to establish consistent definitions and data elements for such services.

5.3.2.2.3 The Contractor shall submit a report to the Department by December 31, 2011 that reflects the progress made by the Contractor in defining these data elements for the RCCOs.

5.3.2.3 *Clinical and Health Status Data Sources.* In the SDAC Expansion Phase, the Contractor shall incorporate into the SDAC Data Repository additional data sources that provide insight into the clinical activities and health status of the Medicaid population. These data will help the Contractor to measure RCCO performance on cost savings and health outcomes.

5.3.2.3.1 The Contractor shall develop and submit a plan to the Department by July 30, 2012 for integrating into the SDAC Data Repository additional data sources that provide clinical and health status information on the Medicaid population.

5.3.2.3.2 The data sources may include registries, electronic health records, and population health data sources. At a minimum the Contractor shall use data from:

1. The Behavioral Risk Factor Surveillance System (BRFSS), a telephone survey conducted by the health departments in all 50 states to collect information on health behaviors and health care access.
2. The Pregnancy Risk Assessment Monitoring System (PRAMS), a surveillance project of the Centers for Disease Control and Prevention and

state health departments, which collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy.

3. The Colorado Immunization Information System (CIIS), a confidential population-based, computerized system that collects and disseminates consolidated immunization information for Coloradans of all ages.

~~Electronic Health Records. The Contractor shall learn about availability of data collected through electronic health records. The Contractor shall capture data that indicate whether or not providers are adhering to the Meaningful Use requirements for electronic health records, as described in proposed federal rules.~~

- 5.3.2.3.3 The Contractor shall obtain data sets for the clinical and health status sources it has identified, and extract, transform, and load the data into SDAC Data Repository.

5.3.2.4 The Colorado Regional Health Information Organization (CORHIO)

CORHIO is charged with assisting in the development of health information exchange processes and workflows to allow for efficient, effective and secure use of data by health care providers and state agencies. At this time, it is unknown when these processes may be developed for the Medicaid program. The Department may request that the Contractor participate in meetings and provide advice on requirements for obtaining ACC Program clinical information directly through CORHIO.

5.3.3 Data Access

The Contractor shall work with the Department to arrange mutual access to data to allow for the smooth exchange of data between them.

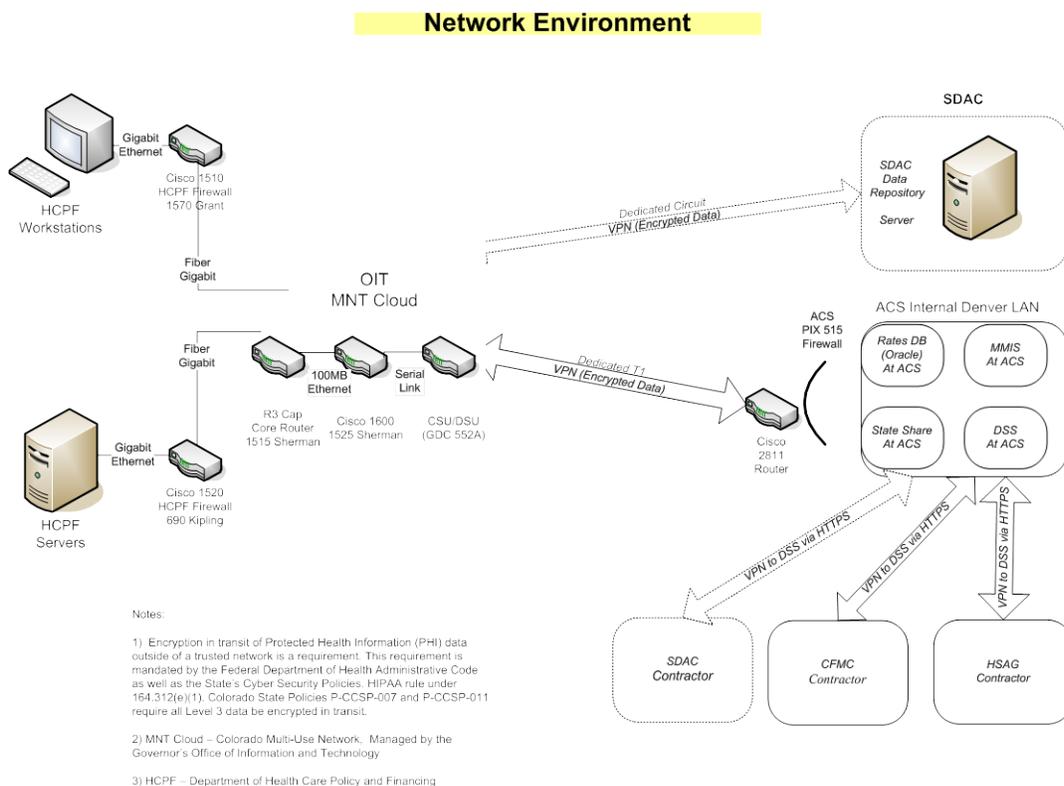
5.3.3.1 Contractor Access to the Department's Data Warehouse

- 5.3.3.1.1 To obtain access to the Department's data warehouse, the Contractor will be authorized to connect to the database through a VPN connection to the data warehouse. The VPN connection requires VPN software and RSA SecureID Tokens. The Department will authorize up to 10 Contractor's users to access the Department's data warehouse.
- 5.3.3.1.2 The Contractor shall access the Department's data warehouse through a VPN connection. The Contractor shall establish and bear the cost of the VPN connection to the data warehouse, requiring VPN software/licenses and RSA SecureID Tokens.
- 5.3.3.1.3 The Contractor shall have a Cognos® license for each user, for remote access to the Department's data warehouse. Cognos® access is through a secure Web site that uses appropriate encryption. The SDAC Contractor shall submit the appropriate access requests and purchase up to 10 Cognos® licenses for each of Contractor's staff accessing the Department's data warehouse. Licenses cannot be shared between users. The Contractor shall bear the cost of each

license. The estimated costs for one user with a Cognos® connection license are listed below:

Cost of Remote Access to the Dept. Data Warehouse	
RSA SecureID Token	\$ 60.00
VPN License	\$ 30.00
IBM Cognos Connection License	\$425.00
Total Costs Per User	\$515.00

The following picture illustrates the Department’s connection to the data warehouse and how the SDAC would connect to the data warehouse, also called the Decision Support System or DSS.



5.3.3.2 Department Access to the SDAC Data Repository. The Contractor shall grant the Department access to the SDAC Data Repository, as outlined below. The Department will coordinate its access to the Repository with the Contractor, so it does not unduly interfere with the Contractor’s ability to perform the services under this RFP. The Contractor shall:

5.3.3.2.1 Grant the Department access to the SDAC Data Repository through a dedicated circuit (VPN encrypted connection that transfer data at 5Mbps) between the SDAC Data Repository and the Department. This is to enable access to reports generated by the Contractor, and their underlying data, to

validate the integrity of the data in the SDAC Data Repository, and use for auditing purposes. The Contractor shall work with the Department and the Governor's Office Information Technology to establish access for the Department to the SDAC Data Repository through the state's firewall and servers. The Contractor is not responsible for maintaining and upgrading the firewall or servers located at Governor's Office of Information Technology.

5.3.3.2.2 Purchase up to 30 user licenses, if needed, for the Department staff to access the SDAC Data Repository. The Contractor shall provide the necessary logins and passwords for the Department to access the SDAC Data Repository.

5.3.3.2.3 Train up to 30 Department staff during each State Fiscal Year to use the SDAC Data Repository.

5.3.3.2.4 The SDAC Data Repository shall be available to the Department 24 hours a day, 7 days a week unless the Contractor provides notice that the SDAC Data Repository will be unavailable. The Contractor shall provide the Department at least 10 hours notice prior to any maintenance that will make the SDAC Data Repository unavailable to the Department.

5.3.4 Data Validation

The ACC Program cannot move into the SDAC Expansion Phase unless it shows budget neutrality and, eventually, cost savings. Because the Program depends on the cost savings reports generated by the SDAC, it is imperative that the data used for the analytics and reporting is valid, reliable and accurate. The Contractor shall assure the accuracy of information contained within the SDAC Data Repository through statistical validation techniques. At a minimum, the Contractor shall establish and run a set of queries created by the Contractor to verify that the data in the SDAC Data Repository is the same as that in the Department's own data warehouse. The Contractor shall:

5.3.4.1 Verify the integrity of the data in the SDAC Data Repository through a robust data integrity quality assurance process. The Contractor shall submit a Data Integrity Quality Assurance Plan to the Department for review and approval by June 30, 2011.

5.3.4.2 Verify the integrity of the data in the SDAC Data Repository by running queries in the SDAC Data Repository and the Department's data warehouse at least once a week following the loading of claims data from the Department to the Contractor.

5.3.4.3 Establish one additional process to verify that the information in the SDAC Data Repository is the same as that in the Department's data warehouse.

5.3.4.4 Establish at least one process to verify that the information in reports generated by the Contractor match the data in the SDAC Data Repository.

5.3.4.5 Refrain from publishing or releasing reports to any entity or provider until the integrity of the data has been verified to the satisfaction of the Department and the Department has approved the content of the reports.

5.3.5 Maintenance and Operations

The Contractor shall support hosting and provide operations support for hosting all associated environments for the SDAC, including development, testing, and production. The Contractor shall ensure that all environmental components (software, hardware, and operating systems) are maintained and up-to-date. The Contractor shall:

- 5.3.5.1 Report any identified data integrity issues to the Department within two business days of the discovery of issues, including recommendations to mitigate the data integrity issues as well as any long-term impacts on data analytics and reports generated for the RCCOs.
- 5.3.5.2 Provide operational monitoring during normal business hours as defined between 8:00 am to 5:00 pm MT and full-time monitoring of all production systems.
- 5.3.5.3 Conduct maintenance based on all production architectural components. This includes scheduled and preventive maintenance, as well as responses to monitoring and incident response needs. **The Contractor shall provide the Department a schedule of routine maintenance and periods when the SDAC Data Repository will be unavailable to the Department upon implementation of the Data Repository. The Contractor may update the schedule as needed. Routine maintenance and other scheduled periods when the SDAC Data Repository will be unavailable to the Department shall not include any period between 7:00 AM and 7:00 PM MT.**
- 5.3.5.4 Provide alert communications to Department management on major outages that impact operations. These communications are to focus on alerts important to end-users and at appropriate levels of detail.
- 5.3.5.5 Monitor and conduct analysis of data center network, appliances, servers, and data arrays metrics to identify and predict resource deficiencies and existing bottlenecks.
- 5.3.5.6 **Within three business days from receipt of new data feeds, update all environments and live reports as appropriate to reflect the most recent data for all users.**

5.3.6 Monthly Report

- 5.3.6.1 The Contractor shall submit a monthly report on performance of the operations environment that includes the following:
- 5.3.6.2 Transactional performance and analysis reports demonstrating that the system and application is satisfactorily performing.
- 5.3.6.3 Network and system resource metrics indicating data center latency, alarm thresholds and bottlenecks of the system.
- 5.3.6.4 Summary of log and other monitoring tool reports, security reports, outage broadcasts and communications, and performance and capacity analyses.

5.3.7 System Back-Up and Disaster Recovery

System back-up and disaster recovery plans are essential to protect the data in the SDAC data repository. For purposes of this RFP, "disaster" means an occurrence of any kind whatsoever that adversely affects, in whole or in part, the error-free and continuous operation of the ACC

Program, and/or affects the performance, functionality, efficiency, accessibility, reliability, and security of SDAC systems. Disaster events may include natural disasters, human error, computer virus, or a malfunction of the hardware or electrical supply. To ensure this data security, the Contractor shall:

- 5.3.7.1** Establish and maintain daily and weekly back-ups that are adequate and secure for all computer software and operating programs, databases, files, systems, operations, and user documentation (in electronic and non-electronic form).
- 5.3.7.2** Be prepared to support the immediate restoration and recovery of lost or corrupted data or software.
- 5.3.7.3** Maintain full and complete back-up copies of all data and software, stored at an approved site remote from the Contractor's primary site. The Contractor shall maintain or otherwise arrange for an alternative site for its database and hardware in the event of a catastrophic or other disaster event. The back-up site does not need to be located within Colorado.
- 5.3.7.4** Rotate backup tapes off-site on a monthly basis.
- 5.3.7.5** Submit a Disaster Recovery Plan by June 30, 2011 and procedures to the Department that addresses the following:
 - 5.3.7.5.1 Checkpoint/restart capabilities;
 - 5.3.7.5.2 Retention and storage of back-up files and software
 - 5.3.7.5.3 Hardware back-up for the main databases
 - 5.3.7.5.4 Time frames deemed reasonably necessary for complete recovery in the event of a disaster.
 - 5.3.7.5.5 Network back-up for telecommunications.
- 5.3.7.6** Take all steps necessary to fully recover the data and/or system from the effects of a disaster and to reasonably minimize the recovery period for all incidents, events and resolution. Restore regular maintenance and operations of the data warehouse within 30 days in the event of a catastrophic disaster.
- 5.3.7.7** Test recovery operations annually.

OFFEROR'S RESPONSE

The Offeror's Proposal shall address each of the requirements outlined above including:

- 1. Describe the Offeror's proposed system architecture to host and support all components required for data hosting for the ACC Program. This includes the physical installation of necessary hardware, software, database and network components required for implementation of the technical architecture.**
- 2. Describe the Offeror's approach in designing, developing and implementing a data warehouse that integrates data from a variety of data sources, including claims data from the Department's Medicaid Management Information System (MMIS). Describe the Offeror's approach for accommodating the increased volume of data**

that will need to be integrated over the course of the contract.

3. Describe the Offeror's approach to providing a scalable and open architecture which can interface with other systems in the future.
4. Describe the Offeror's approach to extract, transform and load Medicaid data. Offeror's is required to describe an initial solution, based on current data availability, as well as a future solution that accounts for growth of Clients and providers using electronic health records.
5. Describe how the Offeror will be prepared to meet the scheduled phased-in approach for the ACC Program, identifying the risks and associated dependencies as well as proposed strategies to mitigate the risks.
6. Identify instances, if any, where the Offeror believes that data sources not identified in the RFP could be made available, or made available at an earlier time in ACC Program implementation The Offeror is encouraged to specifically identify the data element or elements, the source for the information, and a detailed plan of how the information will be made available at an earlier time and why this is a practical and worthwhile suggestion. When submitting such suggestions, the Offeror shall include in the explanation a specific example or examples that demonstrate their ability to successfully implement the proposal in the proposed timeframe.
7. Describe situations in which the Offeror has had success in scaled implementations where major new database environments have been successfully created in similar timeframes. Specifically, Offerors shall provide details explaining how activities are organized and managed throughout the lifecycle of the project. The Offerors should provide details about methods, tools and templates used to ensure the following:
 - a. Effective program governance and structure;
 - b. Deliverables and activities are completed on time and meet the Department's expectations;
 - c. Resource management and allocation;
 - d. Completion of weekly status reports and facilitation of key meetings;
 - e. Software development quality assurance methodology;
 - f. Consistent communication across the project and with the Department and other entities;
 - g. Effective scope management for changes to either functional and/or technical scope;
 - h. Effective issue and risk management, including conflict resolution; and
 - i. Comprehensive knowledge management.
8. A detailed Work Plan that includes a Gantt Chart that demonstrates the timeline and resources required by both the Offeror for a successful implementation with respect to hosting, data integration and other technical operational requirements.

9. Describe the Offeror’s approach on how it will work collaboratively with RCCOs to identify other data elements that represent any case management information that will contribute to measuring the performance of the RCCOs with respect to cost savings or improvement of health outcomes for ACC Program Members.
10. Describe the Offeror’s approach to data and report validation to ensure that consistent results are achieved when running data queries and generating reports. Describe the processes the Offeror plans to implement to identify any data integrity issues and proven strategies to mitigate issues identified.
11. Describe the Offeror’s approach to ongoing maintenance and operations of the data warehouse, including, but not limited to how the Offeror will monitor and conduct analysis of the data center network, appliances, servers, and data arrays metrics to identify and predict resource deficiencies and existing bottlenecks.
12. Describe the Offeror’s approach to systems back-up and disaster recovery operations and how Offeror will meet the requirements outlined in Section 5.3.7.

5.4 ANALYTICS AND REPORTING

A critical function of the SDAC is to provide sophisticated data analytical services and reports for the RCCOs and the Department to meet the goals of the ACC program in reducing costs and improving the health of the Members. The Contractor will provide data driven insights into opportunities to improve efficiency, health, access to care, and Members’ experience of care. These analytics must be sophisticated and technically sound; even more important, the analytics must be “actionable.” The analytics must be useful for informing decisions and changes in provider behavior or policy that lead to meaningful and measurable improvement in the Member’s health outcome, health cost or experience in the care delivery system.

5.4.1 Analytics and Reporting Plan

The Contractor shall submit a comprehensive analytics and reporting plan to the Department for review and approval within 60 days of the final execution of the contract. The plan shall detail how the Contractor will meet the Department needs described the subsections below on required reports, analytics suite, and ad hoc analytics. Medicaid claims data contains a time lag between the date of service and the date that the claim is paid and the data is available; therefore, the Contractor shall include in the Plan a way to account for this lag.

5.4.2 Required Reports

The ACC Program’s performance is measured by controlling the costs of the Medicaid program and measurably improving the health of Members. Establishing baselines, setting performance targets, measuring performance, and rewarding performance are essential to ensuring and maintaining accountability.

5.4.2.1 Core Reports. At least monthly the Contractor shall:

5.4.2.1.1 Create Member-specific reports that shall include, but are not limited to:

1. Historical Member spending on a per member per month basis, both in aggregate and at the service category level;
 2. Member historical utilization of hospital emergency department services;
 3. Member historical utilization of inpatient hospital services, including a measure of inpatient hospital readmissions at 7, 30, 60 and 90 days from the initial hospitalization;
 4. Members lacking a routine or well care visit in the prior year, or other period as defined by the National Committee for Quality Assurance, or other nationally recognized standards setting body;
 5. Member specific historical pharmacy utilization, including alerts for members with high pill burden, members showing utilization suggesting interaction side effects, Members receiving multiple prescriptions for drugs with risk of abuse, and Members having utilization that is contraindicated because of age, gender, or other factors;
 6. Members whose claims data show a lack of needed vaccinations, as defined by the Advisory Committee on Immunization Practices;
 7. Member historical utilization of MRIs, CT Scans, and X-rays; and
 8. Claims history reports that allow end users the capability to extract transaction data from aggregate analysis, aggregate totals from transaction-level data, and analyze across services, providers, and Clients/Members.
- 5.4.2.1.2 Create reports specific to providers or provider panels that include, but are not limited to:
1. All member specific reporting provided for above, aggregated to the provider or provider panel; and
 2. Member utilization of ambulatory sensitive conditions as defined by the Agency of Healthcare Research and Quality, aggregated to the provider or provider panel.
- 5.4.2.1.3 Create reports that include provider and Member-specific information aggregated for each RCCO.
- 5.4.2.1.4 Create reports that include baseline cost and utilization measures, as well as established benchmarks, against which the RCCO's cost and utilization will be measured to track progress. The Department will provide three years of claim data in order for The Contractor to calculate initial baseline metrics. The Contractor shall establish benchmarks for utilization measures using local, regional and statewide performance, as well as national data and standards.
- 5.4.2.1.5 Adapt reporting capabilities to accommodate complications related to variations in claims data. Specifically, the Contractor shall address the following data issues:
1. Over a third of the primary care paid for by the Department is delivered via

Federally Qualified Health Centers (FQHCs). The claims data from the FQHCs generally lacks Common Procedure Terminology and Healthcare Common Procedure Coding System codes. The Offeror shall explain how it plans to accommodate in its analytics the lack of this data.

2. Colorado is the site of a Medicare Acute Care Episode Demonstration where payments by Medicare for hospital and physician services are bundled together in one payment. For members enrolled in the RCCO, and dually eligible for Medicare and Medicaid, the Department will pay coinsurance/deductible on the bundle, rather than on the individual items. The Offeror shall explain how it plans to produce its analytics when the hospital and physician data is bundled together.
3. For Medicaid claims data, there is a time lag between the date of service and the date that the claim is paid, requiring the Contractor to balance the need for quick data analysis to respond to recent data, and the need to create utilization and cost analyses that include all relevant claims, given the time lags between date of service and the date the claim is paid (which is when the claims data become available).

5.4.2.2 Incentive Program

5.4.2.2.1 During the **SDAC** Initial Phase, the RCCOs are required to focus on ensuring quality services and managing costs to achieve budget neutrality. Real-time calculations of simple utilization measures by the Contractor will provide the RCCOs with the feedback necessary to adjust strategies to meet budget neutrality goals. To help the RCCO track its progress on managing costs throughout the **SDAC** Initial Phase, the Contractor shall provide monthly calculations of three utilization measures. These utilization measures will provide a quick, easily calculated estimate of whether overall program costs have decreased. The utilization measures shall be calculated at both the regional level and individual PCMP level, taking into account all enrolled Members. At the beginning of the **SDAC** Initial Phase, the Contractor shall calculate regional baseline costs and utilization measures, against which future cost and utilization measures will be measured to track progress. The RCCO performance on utilization measures will not only provide the RCCO and PCMPs immediate and direct feedback on progress toward budget neutrality, but will also be the basis for incentive program. Please see the following table for the initial utilization measures:

Measurement Area	Performance Target	Total Incentive Payment Amount
Emergency Room Visits per 1,000 full time enrollees (FTEs)	Percentage improvement compared to RCCO's own regional FFS baseline for FY10 (or most recently available 12 month period). Targets and baselines will be developed using historical data. The SDAC will establish a	Level 1: 66% of full amount Level 2: 100% of full amount The full amount available for this measure for the RCCO is \$0.33 PMPM and \$0.33 PMPM for the

	<p><u>RCCO-specific baseline</u> using the actual fiscal year FFS experience from the previous year's data.</p> <p>Level 1 Target: Utilization below baseline, but shows less than 5.0% improvement</p> <p>Level 2 Target: Baseline utilization minus 5.0% or more</p>	PCMPs.
Hospital Re-admissions per 1,000 FTEs	<p>Percentage improvement compared to RCCO's own regional FFS baseline for FY10 (or most recently available 12 month period).</p> <p>Targets and baselines will be developed using historical data. The SDAC will establish a <u>RCCO-specific baseline</u> using the actual fiscal year FFS experience from the previous year's data.</p> <p>Level 1 Target: Utilization equal to or below baseline, but shows less than 5.0% improvement</p> <p>Level 2 Target: Baseline utilization minus 5.0% or more.</p>	<p>Level 1: 66% of full amount</p> <p>Level 2: 100% of full amount</p> <p>The full amount available for this measure for the RCCO is \$0.33 PMPM and \$0.33 PMPM for the PCMPs.</p>
Outpatient Service Utilization per 1,000 FTEs MRI, CT scans, and X-ray tests per 1,000 FTEs	<p>Percentage improvement compared to RCCO's own regional per-FTE utilization of MRIs, CT scans, and X-rays FFS baseline for FY10 (or most recently available 12 month period)</p> <p>Level 1 Target: Utilization equal to or below baseline, but shows less than 5.0% improvement</p> <p>Level 2 Target: Baseline utilization minus 5.0% or more</p>	<p>Level 1: 66% of full amount</p> <p>Level 2: 100% of full amount</p> <p>The full amount available for this measure for the RCCO is \$0.33 PMPM and \$0.33 PMPM for the PCMPs.</p>

5.4.2.2.2 This incentive program will be piloted during the **SDAC** Initial Phase. During this pilot period, utilization measures will be calculated and tracked, but the Department will automatically pay an additional PMPM directly to the RCCO and PCMPs. The utilization measures will be calculated and tracked during the pilot in order for RCCOs and PCMPs to monitor how much of the incentive payments would have been earned if the program were operational.

5.4.2.2.3 During the **SDAC** Expansion Phase (beginning July 1, 2012), the incentive payments for the RCCOs and PCMPs will not be paid automatically, but must be earned by meeting the utilization targets. To calculate these payments, the Contractor shall create an additional report that tracks the above mentioned utilization measures but also includes health outcome measurement information. The Department will use The Healthcare Effectiveness Data and Information Set (HEDIS), The Consumer Assessment of Healthcare Providers

and Systems (CAHPS), Healthy People 2020, and its own health improvement efforts to choose priorities and set targets. The Department will also use the standards defined by its Managed Care Measures and Standards Advisory work group, which was created in 2009 and tasked with building accountability into all Department managed care contracts. During the SDAC Expansion Phase of this program, the Department will, in collaboration with the RCCOs, determine which of these measures it will use for future incentive payments. This decision will be based upon regional or statewide health concerns, the regional population, and Department and RCCOs' priorities.

5.4.3 Analytics Suite

5.4.3.1 The Contractor shall provide an analytics suite that provides utilization and financial analysis at the level of the ACC Member, the provider (or provider panel), and the RCCO. The Contractor shall supply an off-the-shelf, ready-made suite of standard, pre-designed analytic tools. The Department prefers the Contractor supply a ready-made analytics suite able to meet all of these functions without modification, but is willing to consider proposed analytic suites that require the Contractor modifications to meet required functions and reports.

5.4.3.2 These off-the-shelf software tools, which are based on an input of standardized health care claims data, can provide immediate assistance and information to the RCCOs, with very little expenditure of time and resources by programmers or analysts. The Department encourages the use of such tools, which the Department assumes can be supplied by a Contractor at lower cost than custom-built reports. The Department assumes that off-the shelf software tools could provide dozens or hundreds of pre-built reports that provide actionable information to the RCCOs and their affiliated providers.

5.4.3.3 The Department envisions that the analytics suite will contain three core functions. The Department requires that each of the functions be able to be done, but does not require a separate report for each function. The Department prefers, but does not require, that these core functions be woven together, potentially with a single dynamic structure, which is able to be manipulated by users. This would allow a viewer of the data to seamlessly move between and drill up or down within reports. The analytics suite shall:

5.4.3.3.1 Provide for profiling of individual clients based upon predictive modeling. Based upon a predictive model, the Contractor shall develop a numeric score for each RCCO enrolled member to indicate the likelihood that the member is at risk for high medical costs in the near future. The calculation of the numeric score shall include a consideration of prior period utilization or costs, and should consider enrollee diagnosis, including co-morbid diagnoses.

5.4.3.3.2 Identify areas for clinical process improvement at the client, provider, and RCCO level. For example, the suite should be able to generate a report that identifies clients who are not receiving optimal care. Reporting in the suite may include identification of clients who are not receiving primary care timely after hospitalization or clients who are not refilling maintenance medications.

PCMPs should be able to sort through their patient panels, and find clients who are not receiving optimal care, who could be the target of a clinical intervention. The suite shall be able to generate provider profiles that show which providers are cost or utilization outliers.

5.4.3.3.3 Provide for aggregate reporting of cost and utilization that is able to be subdivided on service lines. The Department requires that the aggregate reporting be structured to provide comparisons between cost and utilization between clients, providers, and the RCCOs. The Department requires that these comparisons be able to be risk adjusted. For example, comparison of certain metrics, such as hospital admissions per thousand lives across providers, needs to be risk adjusted in order to account for differences in acuity between the patient panels of those providers.

5.4.3.4 Have reports that are designed to allow the RCCO or PCMPs to enter a variety of parameters to change scope – for example, by Member, over time, by medical condition - which will allow for a more granular or more aggregated view of the data in the reports. Additionally, the reports shall provide functionality to permit end-users to modify reports and arrange, limit, sort, and stratify the data in a variety of ways.

5.4.4 Consulting, Ad Hoc Analytics and Reporting

The Department plans to request additional analysis and consulting from the Contractor. Though the Department anticipates the Contractor will deliver a very large number of standardized, yet flexible reports, the Department is also sure that no off-the-shelf software tool will be able to meet all of the analytical needs of the RCCOs, PCMPs, and the Department. The Department needs to ensure that the analytic capabilities grow with the program, and needs flexibility to answer questions that arise, requiring consultation and strategic use of available data and analytics capabilities.

The Department may request additional consulting, ad hoc analytics, and reports. The Contractor shall have qualified staff available on a timely basis to perform the consulting project or ad hoc reports. Staff who are performing the base services may not be utilized for the pool hour projects or ad hoc reports without the advance, written approval of the Department. Projects may include or be similar to those described below:

5.4.4.1 Consulting, Ad Hoc Analytics and Reports Using Claims Data. Ad hoc analytics reports using claims data shall be designed to allow the RCCO or affiliated providers to use claims data flexibly, in a variety of ways. The Contractor may conduct analyses that may include but are not limited to:

5.4.4.1.1 Analysis of utilization for Members with conditions that are preference-sensitive, meaning there are two or more medically acceptable options and choice should depend on patient preferences. Such an analysis could be at the ACC Member, provider, and RCCO level.

5.4.4.1.2 Analysis of ACC Member disenrollment and enrollment (“churn”) rates by provider.

5.4.4.1.3 An extension of the Core Analytics which provides analysis for a particular subset of a provider panel or RCCO's Membership based upon identified factors such as participation in a certain Home and Community Based Services waiver.

5.4.4.2 Consulting, Ad Hoc Analytics and Reports Using Other Data Sources. The Contractor may be required to perform analytics that use additional data sources in the **SDAC** Expansion Phase. As these data are integrated into the SDAC Database Repository, the Department may request additional ad hoc analytics and reporting. Examples of these analytics and reporting include, but are not limited to:

5.4.4.2.1 Analyses that give providers access to all laboratory, diagnostic, or imaging test, regardless of which provider ordered the tests.

5.4.4.2.2 Analyses of extracts of case management data from the RCCOs relative to claims utilization and costs.

5.4.4.2.3 Analyses of qualitative assessments that identify Member abilities, needs, preferences, and supports.

5.4.4.2.4 Analysis of clinical follow up to medical conditions identified in a hospital emergency department visit.

5.4.4.2.5 Analysis of the relationship of certain clinical interventions to per member per month cost.

5.4.4.2.6 Analysis of certain provider referral patterns, such as a referral of ACC Members to nursing facilities for long-term care rather than potentially less expensive community alternatives.

5.4.4.3 Process for Requesting Consulting, Ad Hoc Analytics and Reports

5.4.4.3.1 There will be an amount set aside within the fixed price for each SFY for consulting, ad hoc analytics, and reports. This is a pool of hours which will be available for consulting, ad hoc analytics and reports which may be requested by the Department.

5.4.4.3.2 For SFY 2010-11, there are 1,000 hours available for this work. **For SFY 11-12 there are 4,000 hours available for this work.** For every fiscal year thereafter, there are 6,000 hours available for this work. There will be a fixed hourly rate for these "pool hours," which the Offeror will propose on the Price Proposal Sheet, Appendix J.

5.4.4.3.3 Projects for consulting, ad hoc analytics, and reports will be initiated by the Department by a written request for an estimate of hours which includes a description of the services needed. The contractor shall respond, in writing, to requests for estimates provided by the Department within three business days of receipt. The Department must review and approve the number of hours for a project prior to the commencement of the work. The Contractor may bill for hours expended on an approved project at the hourly rate up to the approved number of hours for a project. Invoices shall itemize each project and provide detail of the hours expended.

OFFEROR'S RESPONSE

The Offeror's response shall provide a detailed data analysis plan, which demonstrates the Offeror's ability to quickly deliver the Department specified Core Analytics. The Offeror's response should address all requirements above, including at least the following elements:

1. Provide a draft analytics and reporting plan.
2. A step-by-step description, including each logical step of the Offeror's process for turning the raw claims data hosted on the Offeror's server into the required analytics. The Offeror should not include SQL code, or pseudo code, but the Offeror should provide comprehensive logical and technical detail.
3. For each of the analyses contained in the Core Analytics, the Department requires a narrative description of the Offeror's process for creating the analytic deliverable. The Offeror shall include the following items in its response:
 - a. The Offeror's approach to parsing the universe of Department's claim data to the subset used in the analysis; and
 - b. The Offeror's approach to taking the granular raw data, and summarizing to an aggregate level.
4. Describe how its approach to data architecture will impact its above described processes of parsing and summarizing the data.
5. Describe functioning and output of the Analytics Suite that it will provide. The Department understands that the Offeror will be using a variety of software tools to create those deliverables, and requires a detailed description of the software logic for each step of the process. An assertion that the software accomplishes a task in the process, -- without a description of the logic of that process -- does not respond to this request.
6. List, in detail, the turnkey analytics that will be immediately available from the Analytics Suite upon implementation. The Offeror shall provide a narrative to accompany the list of analytics within the Suite. That narrative must include a description of the deliverable and an explanation of how the RCCO can be expected to use the analysis in improving cost efficiency, health outcomes, or patient experience. Concrete and actual demonstrations of the efficacy of the particular variable in prior process improvement initiatives under other contracts should be documented and explained, if available. The Department will consider the scope and number of promised deliverables, and their salience to the policy goals of the Department outlined in the background section of this RFP.
7. Explain its plan to adapt analysis and reporting to:
 - a. Address complications related to variations in claims data, such as FQHC claims data and Medicare Acute Care Episode Demonstration payments; and
 - b. Balance the need for quick data analysis on recent data, and the need to create utilization and cost analyses that include all relevant claims, given the time lags between date of service and the date the claim is paid (which is when the claims data become available).

8. **For the purposes of performance measurement of RCCOs or PCMPs, data analysis and reporting will not be comparable across populations without appropriately risk-adjusting for differences in the provider case mix. Describe the Offeror’s approach to risk-adjustment of measures in which costs and utilization are affected by variation in member acuity, and explain why this is the most appropriate approach.**

5.5 SDAC WEB PORTAL

5.5.1 Web Portal Objectives

The SDAC Web Portal is intended to provide accurate, usable and timely information to the Department, RCCOs and PCMPs. This technological library of data is intended to efficiently support the goals of the ACC Program and provide easy access to all pertinent information, allowing for the smooth and efficient flow of information among all parties. The Contractor shall define the content, format, sort sequence, and scheduled postings and maintenance of data, analytics and reports provided on the SDAC Web Portal.

The Department expects to work collaboratively with the Contractor to continuously improve the functionality of the SDAC Web Portal. The Department will work with the Contractor to create increased capabilities of the SDAC Web Portal over the course of the contract period, to include enhancements including but not limited to the following:

- 5.5.1.1 The Department will work with the Contractor to establish functionality so that once the user has logged on and been authenticated in the Department’s Provider Web Portal, the user may choose to be directed to the SDAC Web Portal without the need for an additional logon and password.
- 5.5.1.2 The Department will work with the Contractor to establish Member access to the SDAC Web Portal.
- 5.5.1.3 The Department desires that the SDAC Web Portal contain an application that allows **authenticated** users to search and query the SDAC Data Repository. The Department will work with the Contractor to **define the search and query parameters as needed**.

5.5.2 Web Portal Functionality

The Contractor is responsible for making claims data, analytics reports and any other necessary data easily accessible from the Web Portal to the Department staff, RCCOs, PCMPs, the Department’s utilization management contractor, the Department’s enrollment broker, and other authorized entities as identified and directed by the Department. The Contractor shall design the SDAC Web Portal to be the central Web-based platform that provides the library of reports and data for the ACC Program. The Contractor shall design, develop and implement the SDAC Web Portal using thin-client architecture executed solely within the framework of a Web browser and based on guidance and input by the Department. The Contractor shall operate and maintain all components for the SDAC Web Portal, including hosting servers and services. The Contractor shall develop and implement user specific dashboards to provide easy and intuitive access to data, analytics and reports for the efficient and effective operation of the ACC Program by

September 30, 2011.

The Contractor shall include the following in the SDAC Web Portal:

- 5.5.2.1 The ability for users to access the SDAC Web Portal via a secured logon, using a logon mechanism to provide users appropriate access to the SDAC data and reports.
- 5.5.2.2 The ability for all users to view and download available reports deemed appropriate for all users to view.
- 5.5.2.3 The ability for users to view and download all data, analytics and reports that are specific to the user defined by the user's profile and security access.
- 5.5.2.4 Separate dashboards for Department staff, RCCOs, PCMPs, the Department's utilization management contractor, the Department's enrollment broker, and other authorized entities as identified and directed by the Department.
- 5.5.2.5 The ability for users to access and utilize the SDAC Web Portal and associated applications from all major browsers (including Internet Explorer, Firefox and Safari).
- 5.5.2.6 The Contractor shall design the SDAC Web Portal for the capacity of at least 1,500 concurrent users.

5.5.3 Security

The Contractor shall establish appropriate security levels for personal health information, claims data, report types. The Contractor shall establish user logons and passwords, and verify that the user's security profile is sufficient to protect the personal information of Clients, Members, and providers. This includes maintaining the appropriate level of security to protect confidential information as specified in the Colorado Cyber Security Polices and HIPAA requirements (See Section 4.5 of this RFP).

5.5.4 Operational Readiness

- 5.5.4.1 The Contractor shall demonstrate the operational readiness of the SDAC Web Portal prior to implementation by satisfactorily completing the following tasks:
 - 5.5.4.1.1 Establish a protocol to assign SDAC Web Portal user logons and passwords upon receipt of necessary documentation, to verify that the user is authorized to view Member and provider information.
 - 5.5.4.1.2 Hire and train qualified personnel to appropriately staff the SDAC Web Portal Help Desk, to successfully perform the required responsibilities to meet and exceed performance expectations.
 - 5.5.4.1.3 Prepare outreach materials for users with sufficient and detailed instructions on how users can access and use the information within the SDAC Web Portal, including Help Desk contact information.
 - 5.5.4.1.4 Conduct a formal readiness walkthrough with the Department demonstrating the Contractor's ability to implement the SDAC Web Portal by June 30, 2011.

5.5.5 Operational Support and Maintenance

Upon implementation of the SDAC Web Portal, the Contractor will provide ongoing operational support and maintenance that includes the following:

- 5.5.5.1 Provide the user logons and passwords to authorized users (all RCCOs and their PCMPs) by July 30, 2011.
- 5.5.5.2 Operate and maintain the SDAC Web Portal according to Department-approved requirements. All processing shall be executed on a central server, except when sending or receiving data.
- 5.5.5.3 Ensure the SDAC Web Portal is continually available to users 24 hours a day except for regularly scheduled maintenance and updates based on a schedule submitted to and approved by the Department.
- 5.5.5.4 Monitor the daily operations of the SDAC Web Portal and supporting functions.
- 5.5.5.5 Define user roles and permissions within 60 days of the final execution of the contract.
- 5.5.5.6 Establish user logons and passwords, verifying that the user's security profiles are sufficient to protect personal health information in accordance with applicable federal and state laws. This includes maintaining the appropriate level of security to protect confidential information as specified in the Colorado Cyber Security Policies and HIPAA requirements.
- 5.5.5.7 Ensure that operations personnel are accessible to the Department personnel, from 8:00 a.m. to 5:00 p.m. Mountain Time, Monday through Friday, except for State holidays. Additionally, ensure that operations personnel are available after 5:00 p.m. Monday through Friday, and on weekends. **The Department shall notify the Contractor of this need for night and weekend availability no later than 3:00 p.m. on Friday for weekend availability and no later than 3:00 p.m. Monday through Thursday for need for availability on those days.**
- 5.5.5.8 Submit an operational incident and resolution report to the Department when operational problems occur with the SDAC Web Portal, describing the nature of the problem, the expected impact on ongoing functions, a corrective action plan and the expected time of problem resolution. The reports shall be submitted no later than the close of business on the day the problem is identified.
- 5.5.5.9 Monitor failed user logon attempts to the SDAC Web Portal and report this information to the Department in the Contractor's Weekly Status Report.
- 5.5.5.10 Notify the Department via e-mail and phone within 30 minutes when five or more unsuccessful attempts within one 24-hour period on a single logon users ID or when the Contractor becomes aware of any other suspicious activity regarding the security of an account.
- 5.5.5.11 Notify the Department via e-mail and phone within five minutes if the Contractor determines that the Web Portal is unavailable. The Contractor shall also notify the Department via e-mail and by phone within five minutes when the Web Portal is restored.

5.5.5.12 Conduct maintenance based on all production architectural components. This includes scheduled and preventive maintenance, as well as responses to monitoring and incident response needs.

5.5.6 Web Portal Help Desk Support

The Contractor shall provide help desk support services for all users that access the SDAC Web Portal. This includes providing advanced technical and functional support for accessing reports, applications, claims data and all other data available in the SDAC Web Portal. The Help Desk will provide real-time online assistance to all users in accessing and utilizing functions within SDAC Web Portal as well as a statewide, toll-free help line available from 8:00 am to 5:00 pm Mountain Time, Monday through Friday, except for State holidays.

Operation of the Help Desk and the statewide toll-free help line will commence on July 1, 2011 or upon implementation of the SDAC Web Portal and will provide real-time online assistance to all users in accessing and utilizing functions within the Web-based applications. The Contractor shall:

5.5.6.1 Maintain and staff sufficient toll-free lines for provider inquiries to meet the following performance expectations:

5.5.6.1.1 Call wait times no longer than 1 minute per 15 calls per hour.

5.5.6.1.2 Abandonment rate no more than 5% of calls per 15 calls per hour.

5.5.6.1.3 98% of all online interactive chat will be responded to within 15 seconds.

5.5.6.2 Provide appropriate staff to respond to user inquiries (via phone or e-mail) on the use of the SDAC Web Portal and provide assistance to users that submit Help Desk tickets, including account access issues and password or account resets for the SDAC Web Portal.

5.5.6.3 Resolve all Help Desk calls regarding the SDAC Web Portal and transfer or direct all calls regarding questions or issues beyond the Contractor's statement of work to the appropriate person or entity.

5.5.6.4 Provide a call management system or supply phone company reports of all line activities, busy signals, hang-ups, non-connects and internal reports of number of calls answered, number of calls put on hold and the length of time each call was held.

5.5.6.5 Post messages and/or alerts on an as-needed or Department-requested basis to alert users of SDAC Web Portal changes or system downtimes.

5.5.6.6 Create, update and maintain Frequently Asked Questions based on calls received, changes made to the design of the SDAC Web Portal, changes to documents locations, etc.

5.5.6.7 Maintain an automated logging and tracking system for all user inquiries (verbal and written). At a minimum, the tracking system shall record the date of the inquiry, the form of the inquiry (e-mail or telephone), the specific nature of the inquiry, the form of response, the date of response, the respondent and relevant comments. The system shall store this information, at a minimum, by date of inquiry and user logon

ID.

5.5.6.8 Provide the Department with Weekly Status Report summarizing all calls answered and timeliness of written correspondence, according to Department specifications.

5.5.7 Disaster Recovery Plan

The Contractor will submit a Disaster Recovery Plan for the SDAC Web Portal to the Department by **June 30**, 2011 or upon implementation of the SDAC Web Portal. The Disaster Recovery Plan should include a detailed description of actions the Contractor will engaged in the event of a system failure which will disrupt the ability of users to access the SDAC Web Portal or reports for more than one business day. The plan should highlight system maintenance procedures, backup providers, recovery procures and business continuity plans.

5.5.8 Interim Plan for Distribution of Data and Analytic Reports

As identified in Section 5.2, the RCCOs and PCMPs will be operational on either April 1, 2011 or June 1, 2011 and will require data that will help to support them in achieving the goals of the ACC Program. As a result, the Contractor shall be required to develop an interim plan outlining how data and analytic reports will be distributed to RCCOs and PCMPs before the SDAC Web Portal is operational.

5.5.8.1 The Contractor shall submit an interim plan within 30 days of final execution of the contract to provide data and analytic reports to RCCOs and PCMPs.

5.5.8.2 The Contractor shall outline in the interim plan the method(s) of distribution, frequency and contents.

5.5.8.3 The Contractor shall submit the interim plan to the RCCOs for input prior to submission to the Department for approval.

5.5.8.4 Upon the Department's approval of the Contractor's interim plan, the Contractor will distribute the data and analytic reports to the RCCOs and PCMPs until the SDAC Web Portal is fully operational as determined by the Department.

OFFEROR'S RESPONSE

The Offeror shall describe its approach to designing, developing, testing, implementing and maintaining the SDAC Web Portal. The Offeror shall describe its ability to meet all the requirements described in this section. The Offeror's response shall emphasize the following:

- 1. Methods for prioritizing the development of reports made available in the SDAC Web Portal;**
- 2. Approach to report and dashboard design, development and implementation;**
- 3. Quality assurance processes to test reports prior to deployment in the SDAC Web Portal;**
- 4. Methods to assign SDAC Web Portal user logons and passwords upon receipt of**

necessary documentation to verify the user authorization to view private health information.

5. **Methods to design, develop, and implement the ability for users to view and download data, analytics and reports that are specific to the user defined by the users profile and security access;**
6. **Methods to develop the SDAC Web Portal to contain user specific dashboards to provide easy and intuitive access to data, analytics and reports for the efficient and effective operation of the ACC Program.**
7. **Methods to ensure the appropriate level of security to protect confidential information as specified in the Colorado Cyber Security Polices and HIPAA requirements. Include:**
 - a. **A description of how the Offeror will authenticate users;**
 - b. **A description of how the Offeror identifies inappropriate user access of data; and**
 - c. **A description of how the Offeror records user access.**
8. **Offeror's ability and expertise in providing help desk support for both functional and technical assistance relative to the SDAC Web Portal.**
9. **The Offeror shall describe the interim plan to provide data and analytic reports to RCCOs and PCMPs prior to the SDAC Web Portal being fully operational that include:**
 - a. **How the materials will be distributed;**
 - b. **Data and analytic reports the Offeror expects will be available to distribute;**
 - c. **How the Offeror will assist the RCCOs and PCMPs in interpreting the data and analyst reports; and**
 - d. **Security to protect confidential information.**

5.6 ACCOUNTABILITY AND CONTINUOUS IMPROVEMENT

The ultimate success of the ACC Program is dependent upon establishing a partnership and interdependency between the work performed by the RCCOs and their PCMPs, the Department, the utilization management contractor, the Medicaid fiscal agent and the SDAC. Just as the RCCOs will be held accountable for achieving cost containment and Member health goals, the SDAC is expected to assume a similar responsibility for achieving the overall ACC Program goals. The SDAC will have a specific and distinct responsibility for calculating the performance of the program on cost savings goals, but the SDAC will also be responsible for fostering continuous improvement and accountability for reaching program goals. The SDAC shall work collaboratively with the Department and the RCCOs to identify opportunities that must be addressed as well as point to solutions and best practices. To achieve this level of collaboration and accountability, the Department has set up an Advisory Committee structure and other methods for promoting communication and partnership. The Contractor shall be responsible for

participating in these processes and for performing specific cost savings analyses.

5.6.1 Advisory Committee Structure

To enable the close collaboration necessary for success, the Contractor shall participate in advisory committees. These committees are formal vehicles through which the RCCOs, the SDAC and stakeholders can advance the principles of continuous improvement and foster an environment of continuous learning. These committees provide a structure for ensuring collaboration and alignment among the key organizations in this initiative. They are a forum for Member input, and a place for clinical experts to provide sound advice on evidence-based standards of care. Finally, they provide a way for the Contractor to share best practices with the RCCOs and to identify opportunities to improve business processes. **The Department expects the Contractor to be physically present for all meetings.**

The Contractor shall facilitate and/or participate in the following advisory committees:

- 5.6.1.1** *SDAC Operations Advisory Committee.* This Committee is directed and chaired by the SDAC Contractor. The Committee shall include representation from each RCCO, the Department, the utilization management contractor, the enrollment broker, and other key players. The Committee will give its members the opportunity to provide the SDAC with feedback about its data collection and reporting interfaces and the usefulness of the data. It will also make recommendations regarding operational improvements, the progress of the Web Portal development by the SDAC, and any other data and analytics activities. **The Contractor shall assist in the production of agenda, meeting minutes and a list of follow-up assignments within three business days following this meeting. The format of meeting documents is subject to review and approval by the Department.**
- 5.6.1.2** *ACC Program Improvement Advisory Committee.* This committee is directed and chaired by the Department and include representation from each RCCO in the state, the SDAC, the utilization management vendor and the provider and Member communities. The Committee provides guidance and makes recommendations to help improve health outcomes, access, cost and Member and provider experience in the ACC Program.
- 5.6.1.3** *Medical Management Oversight Advisory Committee.* This Committee is directed and chaired by the Department's utilization management contractor and includes representation from each RCCO, the SDAC, the Department, clinical experts and the provider community. The Committee provides policy guidance and makes other recommendations regarding medical management for the ACC Program and Colorado Medicaid overall.

5.6.2 Other Meetings

In addition to participating in Advisory Committee meetings, the Contractor shall participate in a variety of other meetings to promote communication with the Department and other ACC Program stakeholders. The Contractor shall identify meeting agenda items related to the Contractor's activity, and provide meeting minutes and a list of follow-up assignments within

three business days following the meeting. These meetings will include, but are not limited to the following:

5.6.2.1 *Contractor Meetings.* The Contractor shall attend regular meetings regarding the status of the performance, deliverables and deadlines described in the contract. Status meetings are held no more than once per week, as determined by the Department. Contract key personnel shall attend these meetings in person, but other Contractor staff may join by conference call. The Contractor shall provide the conference line for those meetings where individuals will participate by conference call.

5.6.2.2 SDAC Steering Team Meeting.

5.6.2.2.1 The Contractor shall work closely with a Department Steering Team, which is responsible for managing and providing guidance to the overall contract. The Steering Team is comprised of the Contractor's Key Personnel, the Department's Deputy Medicaid Director, select Department Division Directors, the Department's Contract Manager, and other Department staff designated to work on this project by the Department.

5.6.2.2.2 The Contractor shall attend regular meetings with the Steering Team. Steering Team meetings are held no more than once per quarter, to be determined by the Department and established annually in the project plan. Contract key personnel shall attend these meetings in person, but other Contractor staff may join by conference call. The Contractor shall provide the conference line for those attending meetings by conference call.

5.6.3 Opportunities and Best Practices

Through its analytics and participation in the Advisory Committee structure, the Contractor will be able to identify opportunities for improvement as well as point its partners towards solutions and best practices, such as interventions that will result in more appropriate utilization of services, better health outcomes, or more effective cost management. Identifying these opportunities and patterns is an important first step, but best practices must be shared and adopted by RCCOs and PCMPs in an effort to make analytics actionable and to further the cycle of continuous improvement. The Contractor shall be responsible for fostering an environment of continuous improvement, for sharing best practices, and assisting RCCOs and PCMPs with adopting these practices. Specifically, the Contractor shall do the following activities to share best practices:

5.6.3.1 *Identifying Opportunities and Best Practices.* The Contractor shall use analytics to identify differences in utilization and outcomes among and within RCCOs and, wherever possible, associate these outcomes to policies, practices or interventions. The Contractor shall recommend best or promising practices based on these analyses.

5.6.3.2 *Disseminating Best Practices.* The Contractor shall disseminate best or promising practices to the RCCOs, PCMPs, and the Department to ensure that the information on these practices is used to improve performance. The Contractor may disseminate this information in a variety of ways, such as presentations at meetings, posts on the

SDAC Web portal, newsletters, or targeted communication to individuals that would benefit the most from the information.

5.6.3.3 *Assisting with Best Practice Adoption.* The Contractor shall identify possible barriers to adopting best or promising practices, and work with RCCOs to develop strategies to overcome these barriers. The Contractor shall provide guidance on how to translate best practices into different environments to make adoption easier and smoother for RCCOs and PCMPs.

5.6.4 Cost Savings

The funding for the ACC Program was approved with the expectation that the program will result in an aggregate reduction of costs of 7%, which fully covers the costs of the program. Because so much is at stake, the Department expects the cost savings analysis to be rigorous and sophisticated. The analysis will include not only data on direct costs of care, but also data that reflect the administrative cost of running the ACC Program. It is important for the cost savings analysis to be transparent and comprehensible to a wide audience, because the analysis produced by the Contractor is likely to have public prominence. For example, it will be cited when the Department provides the fiscal rationale for funding for the expansion of the ACC Program.

5.6.4.1 Cost Calculations for Budget Neutrality in the SDAC Initial Phase

The Contractor shall calculate ACC Program costs for SDAC Initial Phase to determine whether or not the program has achieved budget neutrality. Specifically, the Contractor shall:

5.6.4.1.1 Develop a methodology for calculating programs costs. For example, the Contractor may choose to compare actual ACC Program performance (on a per-capita cost basis) to a risk-adjusted FFS control group cost reduction, or assess actual versus projected costs for ACC Program Members.

1. The methodology shall be detailed, explaining the assumptions made and logical steps of the analysis.
2. This methodology shall be presented in a way that is comprehensive, complete, and understandable to an audience whose expertise is not necessarily in financial analysis or actuarial modeling.

5.6.4.1.2 Prepare preliminary cost calculations for SFY 2011-12 (the period of July 2011 through June 2012) to send to the Department, the RCCOs, and PCMPs, beginning on April 30, 2012 and monthly thereafter until September 30, 2012

5.6.4.1.3 Prepare and submit the preliminary cost savings calculation and analysis report for SFY 2011-12 (the period of July 2011 through June 2012), by June 15, 2012.

1. The Contractor shall include a narrative analysis with this report, describing the methodology used.
2. The analysis shall also include the source of any savings, by provider, service type, eligibility group, or other factor. The Contractor shall also provide an analysis of the cost savings of each of the RCCOs individually.

There are likely to be variations in service delivery approaches among the various RCCOs, and the Department has an interest in determining which of the RCCOs are the most cost effective as well as which RCCOs are the least cost effective or sustainable.

- 5.6.4.1.4 Prepare and submit the final cost savings calculation and analysis report for SFY 2011-12 (the period of July 2011 through June 2012) by November 30, 2012. The Contractor shall include a narrative with this report that includes all of the items required for the preliminary cost report. In addition, the Contractor shall also extrapolate the fiscal impact of expanding the ACC Program to the populations proposed for the SDAC Expansion Phase.

5.6.4.2 Cost Savings Calculations for Shared Savings in the SDAC Expansion Phase

The Contractor shall calculate the program costs and savings on an ongoing basis. Specifically, the Contractor shall:

- 5.6.4.2.1 Make any necessary adjustments to the cost calculation methodology.
- 5.6.4.2.2 Submit quarterly reports that include a narrative that describes the methodology used, and the source of any savings, by provider, service type, eligibility group, or other factor. The Contractor shall also provide an analysis of the cost savings of each of the RCCOs individually.
 1. Starting with the first quarter of State Fiscal Year 2012-13 (July 1-September 30, 2012), submit preliminary quarterly cost savings analysis reports, within 60 days of the end of each quarter. The report for the last quarter shall reflect results for both the quarter and the entire fiscal year. The first preliminary quarterly report is due on November 30, 2012.
 2. Submit final quarterly cost savings reports within 150 days after the end of each quarter, to allow for 120 days of claims run-out plus 30 days to generate the report. The report for the last quarter shall reflect results for both the quarter and the entire fiscal year. The first final quarterly report is due February 28, 2012.

5.6.5 Shared Savings

The Department, the RCCOs, and the SDAC will work together to realize the Department's vision of surpassing budget neutrality to achieving savings. Effective care coordination, reduction of duplicative services, promoting healthy lifestyles and appropriate utilization, coupled with the availability of claims data for providers to use in decision-making and a full-spectrum network with common goals will result in efficiencies and savings beyond the budget neutrality targets.

Examples of such Shared Savings calculations could include annually comparing the actual ACC Program performance, on a per-capita cost basis, to a risk-adjusted FFS control group and/or cost reduction realized versus projected costs for the enrolled ACC Program population.

Funding for Shared Savings will be available no sooner than the State Fiscal year 2011-12, which starts July 1, 2011. The Department may add Shared Savings calculations to the contract by contract amendment.

5.6.6 Transparency of Methods

The continuation of the ACC Program depends largely on the results of the analytics the Contractor performs to measure the ACC Program's success. Therefore, it is essential that the data and methods the Contractor uses for these measurements are transparent to the Department and other stakeholders in the state. These stakeholders may include the Centers for Medicare and Medicaid Services, the Colorado Governor's Office of Information Technology, the Colorado Governor's Office of State Planning and Budgeting, and the Colorado General Assembly, including its committees.

- 5.6.6.1** The Contractor shall provide thorough explanations of work products or deliverables created for this RFP.
- 5.6.6.2** The Contractor shall work with the Department to answer questions or concerns about any methodology, calculations, statistical techniques, or analyses it uses.
- 5.6.6.3** The Contractor shall work in coordination with the Department in the event that defense of work product or deliverables is necessary. These explanations may be in the form of written analysis and testimony or verbal presentations and testimony.
- 5.6.6.4** The Contractor will implement an internal quality control process to ensure that all deliverables, documents, and calculations are complete, accurate, easy to understand, and of high quality. Contractor shall retain all draft and marked-up documents and checklists used in reviewing documents for reference through the duration of the project and project acceptance.

OFFEROR'S RESPONSE

The Offeror shall describe their approach for meeting all Accountability and Continuous Improvement requirements. This includes, but is not limited to the following:

- 1. The Offeror's plans for ensuring continuous feedback and innovation through the use of the advisory committee structure and other meetings, to work collaboratively with the RCCOs and the providers participating in the ACC Program. Where applicable, the Offeror shall provide examples of other contracts in which it has developed relationships directly with an organization similar to an RCCO or directly with Medicaid providers.**
- 2. The Offeror's approach to identifying best practices and opportunities for improvement, as well as strategies for disseminating best practices and helping RCCOs overcome obstacles to implementing these recommended practices.**
- 3. A methodology and work plan for calculating the cost savings, and the accompanying cost savings narrative, of the ACC Program. The Offeror shall describe how this cost savings analysis leverages work performed by the Offeror in the Analytics section of this RFP. This methodology and work plan shall contain a description of the Offeror's strategy to minimize measured selection bias, and other**

measurement bias, in the comparison between the ACC Program enrolled membership and the comparison group. If the Offeror chooses to perform a cost savings analysis in addition to the comparison of the ACC Program enrolled membership to a not enrolled comparison group, Offeror shall explain its rationale, methodology, work plan, and proposed timing.

4. Provide a positive statement of the Offeror's willingness to use data and methods are transparent to the Department and other stakeholders in the state.

5.7 COMPENSATION

5.7.1 Funds Available

5.7.1.1 The total funding available for State Fiscal Year (SFY) 2010-11 is \$750,000. The price proposed for SFY 2010-11 may not exceed the total funding available, including the total amount for the consulting, ad hoc analytics and reports (see Section 5.7.2 below). Price proposals that exceed the funding available for SFY 2010-11 shall be disqualified.

5.7.1.2 The **expected budgeted amount** for State Fiscal Year 2011-12 is \$3,000,000.00 for the required work. The price proposed for SFY 2011-12 may not exceed the **expected budgeted amount**, including the total amount for the consulting, ad hoc analytics and reports (see Section 5.7.2 below). Price proposals that exceed the **expected budgeted amount** for SFY 2011-12 shall be disqualified.

5.7.1.3 The **expected budgeted amount** for State Fiscal Year 2012-13 is \$3,000,000.00. The price proposed for SFY 2012-13 may not exceed the **expected budgeted amount**, including the total amount for the consulting, ad hoc analytics and reports (see Section 5.7.2 below). Price proposals that exceed the **expected budgeted amount** for SFY 2012-13 shall be disqualified.

5.7.1.4 The **expected budgeted amount** for State Fiscal Years 2013-14 and 2014-15 is \$3,000,000.00 for each SFY for the required work for the **SDAC** Expansion Phase. The fixed price proposed for SFYs 2013-14 and 2014-15 may not exceed the **expected budgeted amount**, including the total amount for the consulting, ad hoc analytics and reports (see Section 5.7.2 below). Price proposals that exceed the **expected budgeted amount** for SFY 2013-14 or SFY 2014-15 shall be disqualified.

5.7.2 Consulting, Ad Hoc Analytics and Reports

5.7.2.1 There will be an amount set aside within the fixed price for each SFY for consulting, ad hoc analytics, and reports. For SFY 2010-11, 1,000 hours are provided for this work. For **SFY 2011-12, 4,000 hours are provided for this work.** For every fiscal year thereafter, 6,000 hours are provided for this work. There will be a fixed hourly rate for these "pool hours," which the Offeror will propose on the Price Proposal Sheet, Appendix J.

5.7.2.2 The funding available for SFY 2010-11 for consulting, ad hoc analytics and reports pool hours is \$150,000. Price proposals for hourly rates that when multiplied by the required hours exceed the maximum funding available for pool hour projects shall

be disqualified.

5.7.2.3 The **total amount** for SFY 2011-12 for consulting, adhoc analytics and reports for pool hours is \$600,000. Price proposals for hourly rates that when multiplied by the required hours exceed the **total amount** for pool hour projects shall be disqualified.

5.7.2.4 The **total amount** for SFY 2012-13 for consulting, adhoc analytics and reports for pool hours is \$900,000. Price proposals for hourly rates that when multiplied by the required hours exceed the **total amount** for pool hour projects shall be disqualified.

5.7.2.5 The **total amount** for SFY 2013-14 for consulting, adhoc analytics and reports for pool hours is \$900,000. Price proposals for hourly rates that when multiplied by the required hours exceed the **total amount** for pool hour projects shall be disqualified.

5.7.2.6 The **total amount** for SFY 2014-15 for consulting, adhoc analytics and reports for pool hours is \$900,000. Price proposals for hourly rates that when multiplied by the required hours exceed the **total amount** for pool hour projects shall be disqualified.

5.7.3 Compensation Based on Deliverables

Payments will be made monthly to the Contractor and will consist of a monthly amount and payments for deliverables. A portion of the fixed price compensation will be paid upon satisfactory completion of deliverables. For each State Fiscal Year, the percentage of the fixed price which is not allocated to payments for deliverables will be paid monthly. The number of months in the fiscal year during which the Contractor is performing services will be divided into the percentage of the fixed price which is not allocated to payments for deliverables to determine the monthly payment amount. For each SFY, the deliverables and the percentage of the SFY fixed price which will be paid upon satisfactory completion of that task are described below.

5.7.3.1 SFY 2010-11

- 5.7.3.1.1 **Initiate activities under SDAC Interim Plan for Distribution of Data and Analytic Reports by May 1, 2011: 10%** of SFY 2010-11 fixed price, excluding the “pool” amount.
- 5.7.3.1.2 **Submit ACC Program Client Selection and Attribution Methodology by May 1, 2011: 10 %** of SFY 2010-11 fixed price, excluding the “pool” amount.
- 5.7.3.1.3 SDAC Web Portal and Disaster Recovery Plan: 20% of the SFY 2010-11 fixed price, excluding the “pool” amount.

5.7.3.2 SFY 2011-12

- 5.7.3.2.1 **SDAC Data Repository in production, with three years of claims data loaded, and Disaster Recovery Plan: 10%** of SFY 2011-12 fixed price, excluding the “pool” amount.
- 5.7.3.2.2 **SDAC Web Portal in production and Disaster Recovery Plan: 10%** of the SFY 2011-12 fixed price, excluding the “pool” amount.
- 5.7.3.2.3 **Provide authorized users (RCCOs and PCMPs) with logon and passwords to access the live SDAC Web Portal (Section 5.5.5.1): 10%** of SFY 2011-12 fixed price, excluding the “pool” amount.
- 5.7.3.2.4 **Submit Preliminary ACC Program cost savings calculation and report for SFY 2011-12, by June 15, 2012: 10%** of the SFY 2011-12 fixed price, excluding the “pool” amount.

5.7.3.3 SFY 2012-13

- 5.7.3.3.1 Submit plan for integrating clinical and health status data into the SDAC Data Repository by July 30, 2012: 10% of the SFY 2012-13 fixed price, excluding the “pool” amount.
- 5.7.3.3.2 Submit final ACC Program cost savings calculation and report for SFY 2011-12 by November 30, 2012: **20%** of the SFY 2013-14 fixed price, excluding the “pool” amount.

5.7.3.4 SFY 2013-14 and 2014-15

Deliverables and the portion of the payment amount which will be allocated to the deliverable will be included in the extension amendment for these fiscal years.

SECTION 6.0 OFFEROR’S RESPONSE FORMAT

6.1 GENERAL INSTRUCTIONS

- 6.1.1** The Offeror’s proposal must describe how the Offeror proposes to meet the requirements in the RFP. Each proposal shall describe a comprehensive, quality package of services and programs the Offeror agrees to provide, and demonstrate the Offeror’s ability to partner with the Department to meet its goals related to the ACC Program, and specifically the statewide data analytics and reporting statement of work. The Offeror’s

response must meet all requirements of and respond to all requests for information set forth in this RFP. All requests for information must be addressed, with supporting detail, in the Offeror's proposal. Failure to meet all requirements or to respond to all requests for information may result in the rejection of the Offeror's proposal.

- 6.1.2** The Offeror is required to submit one hard copy original, clearly marked, nine exact hard copies and an exact electronic copy on a CD with each hard copy (10 total) of the Technical Proposal. In addition, the Offeror is required to submit one hard copy original, clearly marked, nine exact copies and an exact electronic copy on a CD with each hard copy (10 total) of the Price Proposal. Electronic copies of both the Technical and the Price proposals on CD must be created with MS Word or Excel, but may be submitted in Adobe Acrobat format.
- 6.1.3** Proposals must be submitted in two parts: a Technical Proposal and a Price Proposal. The Offeror shall submit each hard copy of the proposal in three-ring binders, one for the Technical Proposal and one for the Price Proposal, which will allow the Department to easily incorporate updated pages into the original proposal. The official name of the Offeror's organization, the RFP number, RFP title, and "Original" or "Copy" must appear on the outside of the front cover of each binder. The Technical and Price proposals may be submitted in the same package, but must be in separate binders.
- 6.1.4** The Technical Proposal binder shall include the following items:
 - 6.1.4.1** Transmittal Letter, with the "State of Colorado Department of Health Care Policy and Financing Request for Proposal Signature Page" (the "RFP Signature Page" - see [Appendix B](#)) and W-9 (see [Appendix K](#)). The original of the Transmittal Letter, along with the "State of Colorado, Department of Health Care Policy and Financing, Request for Proposal Signature Page" MUST be signed in ink by the Offeror or an officer of the Offeror legally authorized to bind the Offeror to the proposal.
 - 6.1.4.2** Executive Summary.
 - 6.1.4.3** Table of Contents. The Table of Contents shall list each major section of the proposal, which corresponds to the sections of the RFP.
 - 6.1.4.4** Technical Proposal. Number all pages of the Technical Proposal consecutively from start to finish, including appended materials.
 - 6.1.4.5** Appended materials, if any.
- 6.1.5** The Price Proposal binder shall be numbered consecutively for all pages from start to finish (not required for financial statements), and shall include the following items:
 - 6.1.5.1** Price proposal sheet.
 - 6.1.5.2** Budget.
 - 6.1.5.3** Financial Statements.
- 6.1.6** The Offeror shall adhere to the Department's required proposal format, page limitations and required content. Failure to adhere to these requirements may result in the rejection of the Offeror's proposal. Proposals shall:

6.1.6.1 Use standard 8 ½ by 11 inch paper; 11 x 17 paper may be used for work plans or organization charts; each side of each page will count as one page.

6.1.6.2 Use Times New Roman 12-point font; a smaller font may be used for graphics and references to proposal sections at the beginning of a response; and tables must be in 12-point font.

6.1.6.3 Use 1 inch margins;

6.1.6.4 Include tabs that are keyed to the Table of Contents to separate each section of the proposal.

6.1.7 All proposals must be received by the State of Colorado, Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203 not later than 3:00 PM (MT) on **Tuesday**, November 30, 2010.

6.1.8 Proposals must be submitted in a sealed package, with the following information clearly labeled on the outside of the package:

OFFEROR'S NAME

RFP # HCPFKQ1103SDAC, Data Analytics and Reporting Services for the Accountable Care Collaborative Program

PROPOSALS DUE: **Tuesday**, November 30, 2010 at 3:00 PM (MT)

6.2 TRANSMITTAL LETTER – PAGE LIMIT: FOUR PAGES

6.2.1 The Transmittal Letter shall be concise and signed by an individual authorized to commit the Offeror to the services and fees stated in the Offeror's proposal for the initial contract performance period and renewal years.

6.2.2 The Transmittal Letter shall not exceed four pages.

6.2.3 The Offeror shall submit a Transmittal Letter on its official business letterhead and shall include the following required information:

6.2.3.1 The name, title, e-mail address, mailing address and telephone number of the individual(s) authorized to bind the Offeror to the provisions of the RFP and Draft Contract, and to answer official questions concerning the proposal.

6.2.3.2 Identify all materials and enclosures being forwarded as a response to this RFP.

6.2.3.3 Positive statement of the Offeror's willingness to comply with all requirements described in the RFP, general concept requirements and other terms and conditions specified in this RFP.

6.2.3.4 Positively states that by submitting a proposal, the Offeror affirms its willingness to enter into a contract substantially similar to the terms to the Draft Contract, published with this RFP as **Appendix D**, and indicates the location in the proposal of any requested modifications to **Appendix D**.

6.2.3.5 A positive statement that the submitted proposal shall remain a firm offer for one hundred eighty (180) calendar days after the proposal due date or until the contract

is fully executed, whichever comes first.

- 6.2.3.6** Positive statement that the contents of the proposal (including persons specified to implement the project) will become contractual obligations if the Offeror is selected.
- 6.2.3.7** Identification of the form of business organization (i.e. partnership, non-profit corporation, corporation, etc.) of Offeror. The Offeror's home state must be identified. Non-Colorado entities must register with the Colorado Secretary of State to conduct business in Colorado and appoint a resident agent to accept service of process to conduct business in Colorado. Any foreign corporation, a limited liability company, limited liability partnership, or limited liability limited partnership or other organization must affirm that it currently has a Certificate of Good Standing or Certificate of Existence to do business in Colorado. Secretary of State's website: <http://www.sos.state.co.us/>
- 6.2.3.8** If subcontractors will be used for performance of services, identification for each subcontractor and the services that will be provided by each subcontractor. State that subcontracted work does not collectively exceed fifty percent (50%) of the ~~Total~~ Contract amount, **excluding ad hoc consulting project pool hours**.
- 6.2.3.9** Assurance that the Offeror does not discriminate on the basis of race, color, religion, age, sex, marital status, political affiliation, national origin or handicap, and complies with all applicable provisions of the Americans with Disabilities Act.
- 6.2.3.10** Disclosure of all current or pending contracts with the State of Colorado and all bids or proposals submitted to the State of Colorado but not yet awarded.
- 6.2.3.11** Acknowledgement of number of modifications to this RFP received.
- 6.2.3.12** Positive statement that the Offeror did not submit a proposal in response to RFP # HCPFKQ1102RCCO, Regional Care Collaborative Organizations for the Accountable Care Collaborative Program.
- 6.2.3.13** Identification of all actual, apparent or potential conflicts of interest related to the services described in this RFP and any resultant contract. The conflicts of interest may be personal or organizational. If an actual, apparent or potential conflict of interest exists, include a plan to mitigate the conflict of interest. If a conflict of interest cannot be mitigated or resolved, the proposal may be rejected.
- 6.2.3.14** Acknowledge that by submitting a proposal in response to this RFP, the Offeror is providing the certification described in Section 2.12, Debarment and Suspension. If the Offeror is unable to certify to any of the statements in this certification, provide an explanation as an attachment to the transmittal letter. This explanation is exempt from page limitations on the Technical Proposal. The inability of the Offeror to provide the certification will not necessarily result in disqualification of the Offeror. The explanation will be considered in connection with the Department's determination whether to award a contract to Offeror.

6.3 EXECUTIVE SUMMARY – PAGE LIMIT: TEN PAGES

The Executive Summary shall condense and highlight the contents of the Technical Proposal in

such a way as to provide evaluators with a broad understanding of the entire proposal. It should contain a concise overview summarizing the Offeror's proposal in response to the Data Analytics and Reporting Services for the Accountable Care Collaborative Program RFP, highlighted qualifications of key personnel, a summary of the proposed operational structure for handling the statewide data analytics and reporting responsibilities. The Offeror should emphasize the most important features offered by in its proposed approach and methodology. The Executive Summary should conclude with a discussion of the corporate commitment to the performance of this contract. The Executive Summary shall be no longer than 10 pages.

6.4 TECHNICAL PROPOSAL REQUIREMENTS – PAGE LIMIT: 200 PAGES

- 6.4.1** The Technical Proposal shall not exceed 200 pages. The page limit includes all materials including appendices, exhibits or attachments, but does not include the Transmittal Letter (with attached RFP Signature Page and W-9), Executive Summary, **résumés requested in Section 4, Offeror's Response Item # 7, or sample reports.** **Sample reports,** standard commercial brochures or Member handbooks that are attached as appendices, exhibits or attachments will be counted against page limitations.
- 6.4.2** The Technical Proposal shall present a full and complete description of the qualifications of the Offeror to carry out the requirements set forth in the RFP, as well as the approach and methods the Offeror proposes to use in completing the work. The Offeror's response must describe how it proposes to meet the requirements in the RFP. The proposal must describe a comprehensive quality package of services the Offeror agrees to provide and demonstrate the Offeror's ability as the statewide data analytics and reporting entity.
- 6.4.3** The Offeror's Technical Proposal must contain all of the information requested in Sections 4 and 5 under "Offeror's Response" (in bold font). The Offeror's Price Proposal must contain all of the information requested in Section 6.5 below. To aid evaluators in reviewing proposals, Offeror shall first repeat the language from the RFP that describes which section of the RFP, including the RFP section number the Offeror is responding to (e.g. "Section 5.4, Analytics and Reporting"), followed by the Offeror's response to that requirement.
- 6.4.4** The Offeror shall not assume that there will be an opportunity for revisions of proposals. Therefore, each proposal shall contain the Offeror's best terms from a price and technical standpoint.
- 6.4.5** The Offeror is cautioned to ensure that its proposal adequately describes its proposed program and demonstrates an understanding of the requirements. The proposal should be succinct, self-explanatory and well organized so that reviewers can understand the process that will be used to complete the requirements of this RFP. The Department does not encourage excessive responses and may disqualify proposals that exceed the page limit. Tabular or graphical presentations may be incorporated in the text of the proposal response or separate attachments. However, evaluators cannot be expected to comprehend all material in attachments whose content and relevance to the proposal are not clearly stated.
- 6.4.6** No reference shall be made to any pricing information or elements of cost within the

Transmittal Letter, Executive Summary or the Technical Proposal. If any element of pricing or cost is referred to in the Transmittal Letter, Executive Summary or Technical Proposal, the Offeror's proposal may be rejected.

6.5 PRICE PROPOSAL REQUIREMENTS – NO PAGE LIMITATION

6.5.1 Compensation

The Offeror must complete Appendix J, Price Proposal Sheet, and return the form with the Price Proposal. The following are the requested prices:

- 6.5.1.1 State Fiscal Year 2010-11: The total funding available for State Fiscal Year (SFY) 2010-11 is \$750,000. The price proposed for SFY 2010-11 may not exceed the total funding available, including the total amount for the consulting, ad hoc analytics and reports. The funding available for SFY 2010-11 for consulting, ad hoc analytics and reports pool hours is \$150,000. Submit a fixed price for the services for SFY 2010-11, and an hourly rate for consulting pool hours. Price proposals that exceed the funding available for SFY 2010-11 in total or an hourly rate that when multiplied by the required hours exceeds the maximum funding available for pool hour projects shall be disqualified.
- 6.5.1.2 State Fiscal Year 2011-12: The **expected budget amount** for State Fiscal Year (SFY) 2010-11 is \$3,000,000. The price proposed for SFY 2011-12 may not exceed the **expected budget amount**, including the total amount for the consulting, ad hoc analytics and reports. The **total amount** for SFY 2011-12 for consulting, ad hoc analytics and reports pool hours is \$600,000. Submit a fixed price for the services for SFY 2011-12, and an hourly rate for consulting pool hours. Price proposals that exceed the **expected budget amount** for SFY 2011-12 in total or an hourly rate that when multiplied by the required hours exceeds the **total amount** for pool hour projects shall be disqualified.
- 6.5.1.3 State Fiscal Year 2012-13: The **expected budget amount** for State Fiscal Year (SFY) 2012-13 is \$3,000,000. The price proposed for SFY 2012-13 may not exceed the **expected budget amount**, including the total amount for the consulting, ad hoc analytics and reports. The **total amount** for SFY 2010-11 for consulting, ad hoc analytics and reports pool hours is \$900,000. Submit a fixed price for the services for SFY 2012-13, and an hourly rate for consulting pool hours. Price proposals that exceed the **expected budget amount** for SFY 2012-13 in total or an hourly rate that when multiplied by the required hours exceeds the **total amount** for pool hour projects shall be disqualified.
- 6.5.1.4 State Fiscal Years 2013-14 and 2014-15: The **expected budget amount** for State Fiscal Year 2013-14 and 2014-15 is \$3,000,000 for each fiscal year. The price proposed for SFY 2013-14 and 2014-15 may not exceed the **expected budget amount** for each state fiscal year, including the total amount for the consulting, ad hoc analytics and reports. The **total amount** for SFY 2013-14 and 2014-15 for consulting, ad hoc analytics and reports pool hours is \$900,000 for each state fiscal year. Submit a fixed price for the services for SFY 2013-14 and 2014-15, and an

hourly rate for consulting pool hours. Price proposals that exceed the **expected budget amount** for SFY 2013-14 and 2014-15 in total for each fiscal year or an hourly rate that when multiplied by the required hours exceeds the **total amount** for pool hour projects for each fiscal year shall be disqualified.

6.5.2 Budget

The price proposal shall include a budget that anticipates expenditures in sufficient detail to determine the cost of providing the services described in the Offeror's proposal. The budgets shall be submitted in the template formats provided in Appendix L of this RFP and shall include both a summary and a descriptive narrative. **The budget templates are organized by State Fiscal Year (July 1 to June 30). Please include the budgets for base work only. This includes off-the-shelf solutions, subcontracting, and administrative/operating overhead. Costs for ad hoc consulting projects are not to be included.**

6.5.3 Financial Information

The price proposal must contain a statement that the Offeror has the financial strength to maintain this contract.

Include as an attachment to the Price Proposal true copies of the Offeror's most recent audited annual financial statements. These statements must include a balance sheet and revenue statements for a reasonable number of previous years. The statements must have been prepared by a Certified Public Accountant and meet Generally Accepted Accounting Principle standards. The Offeror must submit one of the following (in order of preference):

- 6.5.3.1** An audited financial statement; or
- 6.5.3.2** A financial statement reviewed by a certified public accountant; or
- 6.5.3.3** A third-party prepared financial statement if an audited or reviewed statement is not available; or
- 6.5.3.4** Another financial statement prepared in the routine course of the Offeror's business.
- 6.5.3.5** This information will be used to assist the Department in making its determination of successful Offeror responsibility in accordance with C.R.S. 24-103-401.

SECTION 7.0 PROPOSAL EVALUATION

7.1 EVALUATION PROCESS

The evaluation of proposals will result in a recommendation for award of a contract under this RFP. The award will be made to the Offeror whose proposal, conforming to the RFP, will be most advantageous to the State of Colorado, price and other factors considered. The Department will conduct a comprehensive, thorough, complete and impartial evaluation of each proposal received.

- 7.1.1** First, all proposals will be reviewed by the Department’s Contracts and Purchasing Section for acceptance. The Department’s Contracts and Purchasing Section will be responsible for ensuring that:
- 7.1.1.1** The Offeror's proposal complied with the due date and time;
 - 7.1.1.2** The Offeror's “State of Colorado, Department of Health Care Policy and Financing, Request for Proposals Signature Page” meets requirements;
 - 7.1.1.3** The Offeror included the appropriate number of proposal copies; and
 - 7.1.1.4** The Offeror was registered with the State of Colorado’s BIDS web site prior to the due date and time.
- 7.1.2** Proposals will then be evaluated by an evaluation committee to determine whether the mandatory minimum requirements in Section 4.1 have been met. The Technical and Price Proposals that meet the mandatory minimum requirements will be evaluated by the evaluation committee using the evaluation criteria listed in the table in Section 7.2 below.
- 7.1.2.1** Criteria will be weighted as stated in the table below to reflect relative importance. Scores from 0 to 5 will be assigned by each evaluator, with 5 being the highest. The score given for each criterion will be based on the evaluators’ assessments of the response, how the responses meet the requirements of the RFP, and whether required statements and submissions were provided. Scores for all evaluators will be multiplied by the weights to determine the number of points.
 - 7.1.2.2** The mandatory minimum requirements are scored on a Met/Not Met basis. In addition, the “Experience and Organization” criterion will be scored based upon the Offeror’s additional experience and proposed organization. The qualifications listed in Section 4.2 are the qualifications necessary for a score of “3”.
- 7.1.3** The evaluation committee may check client references as part of the evaluation process. Reference checks will not be limited to specific references cited in the proposal but may include others.
- 7.1.4** The evaluation committee may, if it deems necessary, request clarifications, conduct discussions or oral presentations, or request best and final offers; however, it may proceed to an award recommendation without any of these activities. Offerors selected to participate in these activities would be those which, based on the scores, are reasonably susceptible of being selected for award. The evaluation committee may adjust its scoring based on the results of such activities, if any. However, proposals may be reviewed and determinations made without such activities and Offerors should be aware that the opportunity for further explanation might not exist. Therefore, it is important that proposals are complete and favorable. The Offeror shall not assume that there will be an opportunity for revisions of proposals. Therefore, each proposal shall contain the Offeror’s best terms from a price and technical standpoint.
- 7.1.5** The committee will then make an award recommendation subject to the final approval of the Department’s Procurement Director. Upon review and final approval of the evaluation committee's recommendation for award, the Department’s Procurement

Director will issue a "Notice of Intent to Make an Award" letter that will be sent to all Offerors, announcing the Department's intent to make an award to the selected Offeror. At approximately the same time, a notification of the award is published on the Colorado BIDS web site.

7.1.6 Failure of a proposal to comply with the requirements of this RFP may result in the proposal being disqualified as a non-responsive proposal.

7.2 PROPOSAL EVALUATION CRITERIA

The Evaluation Committee will use the following criteria in evaluating the proposals and recommending an award.

	Mandatory Minimum Requirements (Section 4.1)	Met/Not Met
1.	Five years, in the last seven years, of experience building, operating, and maintaining a data warehousing capability and capacity that integrates data from a variety of data sources, including experience providing a scalable and open architecture which has interfaced with other systems.	
2.	Five years, in the last seven years, of experience using sophisticated analytics for performance evaluation of complex programs.	
3.	Three years, in the last seven years, of experience developing and hosting a Web Portal that provides reports and other information to designated stakeholders that includes ongoing help desk support for end-users.	
	Technical Proposal	Weight
1.	Experience	100
2.	Organization, Personnel and Subcontracting	50
3.	Security	20
4.	Turnover	10
5.	Client Selection	70
6.	Data Repository	70
7.	Analytics and Reporting	100
8.	SDAC Web Portal	70
9.	Accountability and Continuous Improvement	40
	Price Proposal	Weight
1.	Price	
1.A	Fixed Price	110
1.B	Hourly rate	20
2.	Budget	40

SECTION 8.0 APPENDICES

Appendices are provided as separate documents on the BIDS website.