



Colorado Department of Health Care Policy and Financing



C.R.S. §25.5-5-415
Accountable Care Collaborative
Payment Reform Initiative

Solicitation # HB12-1281 PRI
GUIDELINES FOR PROPOSAL

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INTRODUCTION

The Colorado Department of Health Care Policy and Financing (Department) is soliciting responsive proposals from the Regional Care Collaborative Organizations (RCCOs) to create and implement a pilot program establishing new payment methodologies in the Medicaid Accountable Care Collaborative Program. Proposals must be submitted by organizations currently under contract with the Department as RCCOs (Offerors), but partnering organizations may collaborate in proposal development and implementation, if selected.

General solicitation information, timelines, and proposal submission requirements are available in *Appendix A: Administrative Information* document. To be considered responsive, an Offeror shall comply with all of the requirements and timelines contained in Appendix A.

BACKGROUND INFORMATION

The Department of Health Care Policy and Financing

The Department serves as the Medicaid Single State Agency, as defined by Code of Federal Regulations (CFR) Title 45 Section 205.100 (45 CFR §205.100). The Department develops and implements policy and financing for Medicaid and the Children's Health Insurance Program, called Child Health Plan Plus (CHP+) in Colorado, as well as a variety of other publicly funded health care programs for Colorado's low-income families, children, pregnant women, the elderly and people with disabilities. For more information about the Department, visit www.Colorado.gov/HCPF.

The Department is a Covered Entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (United States Code [U.S.C.] Title 42 Sections 1320d through 1320d-8 [42 U.S.C. §§1320d – 1320d-8]) and its implementing regulations.

Project Background

Accountable Care Collaborative (ACC) Program

The Department implemented the Accountable Care Collaborative (ACC) Program in May 2011 as a Medicaid system reform. The ACC Program represents a committed effort to transform the Medicaid Program into an integrated system of better care for all its members and to lower costs for the State of Colorado. As of November 1, 2012, **177,691** Medicaid recipients are enrolled as members in the ACC Program, representing approximately **27%** of the Medicaid population in Colorado.

The Department developed the ACC Program as a Colorado-specific solution in collaboration with stakeholders. In 2009, the legislature passed a budget action authoring the Medicaid Value-Based Care Coordination Initiative, now known as the ACC Program. Stakeholders have been vital to the design, implementation, and ongoing evolution of the ACC Program, and ongoing stakeholder engagement is continuously achieved through a robust advisory committee process.

The ACC Program is both a short-term solution to improving care and reducing costs as well as a long-term investment in better health futures and savings for the Colorado population. The program design includes an immediate focus on reduction of specific key performance indicators that measure member utilization of services. In addition, better coordination of care will enhance client engagement, as well

as prevention and wellness promotion. This increased focus on proactively managing care is expected to result in better health and reduced costs across the lifespan of current members.

The Department has outlined four goals to guide its efforts moving forward with the ACC Program. The program will:

1. Ensure access to a focal point of care or medical home;
2. Coordinate medical care and non-medical care;
3. Improve member and provider experiences; and
4. Provide the necessary data to support these goals.

Under the ACC Program, the Department currently pays a per-member per-month (PMPM) administrative payment to both the Regional Care Collaborative Organizations (RCCOs) and the Primary Care Medical Providers (PCMPs).

For the purpose of the ACC Program, the state is geographically divided into seven regions, each having one Regional Care Collaborative Organization (RCCO) responsible for all of the ACC members in that region. The RCCOs are responsible for provider network development and support, medical management and care coordination for members, and accountability and reporting. The role of PCMPs is to serve as a focal point of care or medical home for ACC clients. Every member should be linked with a PCMP as his or her central point of care.

The Department developed the ACC Program in response to a statewide increase in the number of Medicaid enrollees and rising costs. The program is designed to serve as the platform for multiple Medicaid system reforms, including payment reform.

House Bill 12-1281

Legislation passed in 2012, HB 12-1281, created Colorado Revised Statute §25.5-5-415, which allows the Department to accept proposals for innovative payment reform ideas that will demonstrate new ways of paying for improved client outcomes while reducing costs. The ACC Program infrastructure will be the vehicle for delivery and payment reforms in Colorado Medicaid, and the RCCOs may submit proposals to the Department for evaluation and possible selection. Organizations partnering with RCCOs may collaborate in the development of proposals and implementation of the pilot, if selected.

The goal of the ACC Payment Reform Initiative is to advance the Colorado Medicaid program toward a value-based purchasing system that promotes the delivery of quality care with quality health outcomes and reduces medical services costs. Building on the goals of the ACC Program, the initiative will further promote accountability at every level and the integration of physical and behavioral health services. This initiative will model a more effective and efficient payment system to guide the future development of Medicaid in Colorado.

CRITERIA FOR PILOT PROPOSALS

General Guidelines

The following items are meant to assist with the development of a proposal and provide general points on the necessary and/or desired components of a successful proposal.

- Proposals shall align with the ACC Payment Reform Initiative’s goal: *To advance the Colorado Medicaid program toward a value-based purchasing system that promotes the delivery of quality care with quality health outcomes and reduces medical services costs.*
- The proposed payment model shall neither perpetuate the existing fee-for-service system nor create a managed care structure that does not add innovative components beyond the traditional HMO model.
- Proposals shall be operationally and programmatically feasible, sustainable, and replicable.
- The Department will give preference to proposals that can demonstrate a cost savings within the contract period (see Appendix A for schedule of activities timeline).
- The Department will give preference to proposals that are submitted on behalf of more than one RCCO and would serve clients across several regions or that can demonstrate participation from multiple payers.
- The Department contracts with Behavioral Health Organizations (BHOs) to provide mental health services to Medicaid recipients statewide with specific mental health diagnoses. In addition, state law restricts long-term services and supports (LTSS) providers from contracting with a risk entity. However, the promotion of integrated care across these systems benefits Medicaid clients and is a desired outcome of the payment reform pilot. To the extent that proposals can include partnerships with BHOs and LTSS providers through other business arrangements outside of Department contracts, these enhanced coordination structures will be given preference.
- Changes to the current ACC Program will require the Department to submit a state plan amendment or a waiver to the Centers for Medicare and Medicaid Services (CMS). Preference will be given to those proposals that are more likely to be approved quickly by CMS.
- The proposed payment methodology shall leverage the Department’s rate-setting systems and structures whenever possible.

Proposal Components

1.0 – Minimum Requirements

Each of these items will be scored as either meeting or not meeting the minimum requirement. To be considered for selection, all minimum requirements shall be met.

1.1 – Budget Neutrality

The proposal shall describe how the payment reform pilot project would meet the requirement to be budget neutral for the project period and achieve cost savings for the Medicaid program over time. Include a justification that either: 1) is evidence-based and cites research or successful examples of the approach or 2) is supported by logical assumptions based on known patterns of health care utilization and cost.

1.2 – Upper Payment Limit and Hospital Provider Fee

If the proposal includes an at-risk arrangement, the RCCO shall describe how the Department can ensure that inpatient and outpatient hospital reimbursements are maximized up to the Upper Payment Limit. Additional Department information on the Upper Payment Limit and the Hospital Provider Fee can be found in the Resources Library section of the Payment Reform Initiative (PRI) web page.

1.3 – Assurances

- 1.3.1. If the proposal includes an at-risk arrangement, the Offeror shall demonstrate that the organization meets all Colorado Department of Insurance regulations and requirements of assuming insurance risk. Managed Care Entities shall meet all requirements of Colorado Revised Statutes §25.5-5-404, including the financial solvency requirements and the essential community providers requirement.
- 1.3.2. Where services are paid outside of the current fee-for-service system, proposals shall provide an assurance that all encounter data will be reported in a Department approved format and schedule. Additional Department information on encounter data submission can be found in the Resources Library.
- 1.3.3. The proposed pilot shall not reduce any services currently provided through the ACC Program or eliminate existing contract requirements for RCCOs and PCMPs.
- 1.3.4. Pilots shall be implemented by July 1, 2014 and end no later than June 30, 2016. Any ramp-up activities shall occur before July 1, 2014.
- 1.3.5. The proposed payment rate shall be based only on currently allowable State plan services and codes. Proposals shall not incorporate coverage of long-term services and supports (LTSS) into a capitated payment structure. Services covered under behavioral health organization (BHO) contracts shall not be included in the rate calculation.

1.4 – Federally Allowable

The proposed pilot model shall be implemented through a federally-allowable managed care contract structure, which includes the following entity types: MCO, PIHP, PAHP, and PCCM (for definitions, see Glossary in the Resources Library section of the PRI web page).

1.5 – Feasibility

The proposed pilot shall be administratively and operationally feasible. This item will be determined using all components of the proposal.

2.0 – Proposed Pilot Description

2.1 – Payment Methodology

Each proposal shall provide a description of the payment methodology using the structure of either the Alternate Payment Option or the Global Payment Option below. The Alternate Payment Option may include any payment model that does not encompass all eligible Medicaid services. Proposals

shall not include any rate amounts but may identify minimum calculations as part of the methodology.

For the **Alternate Payment Option**, the proposal shall address the following items:

- 2.1.1. Describe in detail the rate structure and logic model, including:
 - Covered services and units of service;
 - Risk adjustments; and
 - A description of how the rate structure is tied to value.
- 2.1.2. Identify a minimum of two (2) performance and/or quality measures that are appropriate for the general health profile of the population served through the pilot.
- 2.1.3. Describe how the two (2) measures are incorporated into the proposed value payment model and affect payments.
- 2.1.4. Identify whether the payment model aligns with other health care payers and insurers.

For the **Global Payment Option**, the proposal shall address the following items:

- 2.1.5 Describe in detail the rate structure and logic model, including:
 - Covered services and units of service;
 - Risk adjustments; and
 - A description of how the rate structure is tied to value.
- 2.1.6 Identify a minimum of three (3) performance and/or quality measures that are appropriate for the general health profile of the population served through the pilot.
- 2.1.7 Describe how the three (3) measures are incorporated into the proposed value payment model and affect payments.
- 2.1.8 Identify whether the payment model aligns with other health care payers and insurers.

The aspects of the proposal described in this section shall focus on whether the model is logical, reasonable, and effective.

2.2 – Policy Innovations

- 2.2.1 The proposed model shall enhance the current Medicaid program through one (1) or more policy innovations. The policy innovation(s) shall support all or part of the Triple Aim of improving health outcomes, improving the quality of health care, and/or reducing the cost of health care for Medicaid.

Examples of a policy innovation include (but are not limited to):

- Integration of mental health and substance use disorder services with physical health services
- Prevention, early intervention, and wellness
- Chronic disease management
- Health-related behavior modification
- Client education and support services
- Coverage of additional health services (e.g., dental services for adults)
- Supporting care transitions
- Other strategies that add value to the program and services
- Alignment and coordination with LTSS
- Alignment and coordination with state and/or local public health services
- Alignment and coordination with dental services

2.2.2 In this section, the proposal shall define one or more policy innovation goals or targets that may enhance the Medicaid program. The RCCO shall provide evidence supporting the efficacy of the identified policy innovation(s) or provide a strong rationale based on known patterns in health care utilization and cost.

2.2.3 This section shall also describe how the policy innovation(s) is/are supported by and align with the payment model described in Section 4.1.

2.3 – Cost Savings

If cost savings can be achieved during the contract period, the RCCO may describe in this section the expected mechanism of action and the estimated amount. Include a justification that either: 1) is evidence-based and cites research or successful examples of the approach, or 2) is supported by logical assumptions based on known patterns of health care utilization and cost. The justification shall identify any assumptions or dependencies in the argument.

The aspects of the proposal described in this section shall focus on the strength of the model, the amount of expected savings, and likelihood of a savings outcome. If the proposed pilot model is not expected to result in cost savings, the proposal will not receive credit for the weight of this section.

While budget neutrality during the contract period is a requirement of this solicitation (see Section 1.1), achieving cost savings during the contract period is not a required component of the pilot.

2.4 – Population and Geography

This section of the proposal shall identify the following components:

- 2.4.1 The ACC Program regions or counties in which the pilot shall operate
- 2.4.2 The approximate number or percentage of Medicaid clients included in the pilot
- 2.4.3 The eligibility categories included in the pilot
- 2.4.4 A description of the health needs of the region’s population to be included in the pilot
- 2.4.5 Any identified minimum/maximum enrollment numbers

- 2.4.6 Any other limitations on who may participate
- 2.4.7 Whether the pilot would include Medicare-Medicaid enrollees and how it would align with Medicare

If the proposed pilot would serve full benefit Medicare-Medicaid eligible enrollees who may be included in the State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees, the Applicant shall note that additional administrative work may be required to gain approval from CMS.

The aspects of the proposal described in this section shall focus on completeness, alignment with the identified policy innovation(s) and payment methodology, and the RCCO's understanding of the population's health needs.

2.5 – Provider Network and Structure

This section of the proposal shall describe the following components.

- 2.5.1 The provider network for all applicable services
 - The participating PCMPs and other providers of primary care
 - The participating providers who will accept pilot payments under a non-FFS structure
 - Any other providers or provider types that may continue to serve pilot clients under the regular FFS payment structure
- 2.5.2 How providers will coordinate care for the pilot population
 - Any additional support or coordination provided by the RCCO
 - Whether care coordination will be delegated to providers in a manner differing from current ACC Program arrangements (if yes, describe)
- 2.5.3 Any potential impact on provider satisfaction and participation
 - Whether and how this proposed pilot might be expected to attract additional non-contracted PCMPs or other non-Medicaid providers
- 2.5.4 Provider burdens and responsibilities
 - Any additional administrative burdens on the participating providers
 - Any additional responsibilities for participating providers as compared to current practices under the ACC Program
- 2.5.5 The reimbursement methodology, including how the rate structure is tied to value
 - How providers will be paid for services
 - How performance and/or quality affect provider payments
- 2.5.6 Whether the pilot aligns with a broader approach that may reduce the administrative burden on providers

- Any other payers/entities that are planning to use the described pilot model as the basis for provider payments
- How model might align with other governmental initiatives through Medicaid or Medicare
- Whether more than one RCCO will be partnering to implement the pilot

2.5.7 If other payers have demonstrated interested in aligning with the proposed pilot, the Offeror shall attach a letter of attestation from each participating entity to the application.

The aspects of the proposal described in this section shall focus on how the provider network and payment structure will effectively support the policy innovation(s) and goals of the proposed pilot, how it may potentially increase provider satisfaction and participation in Medicaid, and how the proposed network will effectively support the population identified in Section 2.4. Proposals that include a multi-payer or multi-RCCO approach will be given preference.

2.6 – Health Outcomes and Client Centeredness

2.6.1 All proposals shall describe how quality measures based on their patient population will be used in the pilot. If the pilot calls for claims adjudication and payment through the MMIS, the Department will calculate those measures based on claims data. If the pilot does not call for MMIS claims adjudication and payment, performance on these measures shall be reported to the Department no less than quarterly. There may be some proposals for which the listed measures are not appropriate. In these cases the proposal shall address those measures and include additional measures tailored to the pilot population. For example, a pilot addressing asthma patients may not choose to use the diabetes measure but uses instead a measure looking at emergency department visits for clients with asthma.

If a proposal chooses to do so, it shall describe:

- Why are these other quality measures more appropriate for the target population of the proposal?
- How will the data be collected and reported? Will data be collected and reported by the Department? Or some other means?
- How will data be incorporated into the SDAC?

The list below is derived from the Centers for Medicare and Medicaid Services (CMS) Core Measures for Adults and Children in Medicaid. Additional measures were added in areas that were felt to be lacking (i.e. utilization, provider satisfaction, and care coordination). This list provides a minimum set of measures that address quality of care across all three domains of the Triple Aim (patient experience, population health, and total cost of care). These measures are required to be reported for measurement purposes alone and to align payment reform initiative efforts with the Department's reporting obligations to CMS.

The reporting of these quality measures serves two purposes: it provides the Department with an estimate of the quality of care it is purchasing and provides information to providers and networks to identify areas for improvements.

Proposals do not need to link payment to the list of quality measures. However, quality measures may be part of, and are encouraged to be, the strategy of how a rate structure is tied to value under the payment methodology in Section 4.1.

The Department either currently collects or has plans to collect all of the measures listed below with region specific data. Proposals may collect and report quality measures not listed below that are more appropriate measures of the quality of care delivered to the target population of the proposal.

Proposals that use a global payment model shall at minimum collect and report this list of quality measures on its target population.

Pilot Population	
Adults	Children
<p>Utilization of services</p> <ul style="list-style-type: none"> • All cause readmissions, as measured by the ACC Program’s KPI methodology • Emergency room visits, as measured by the ACC Program’s KPI methodology • High-cost imaging services, as measured by the ACC Program’s KPI methodology • Inpatient hospital services • Prescription drugs • Office visits 	<p>Utilization of services</p> <ul style="list-style-type: none"> • All cause readmissions, as measured by the ACC Program’s KPI methodology • Emergency room visits, as measured by the ACC Program’s KPI methodology • High-cost imaging services, as measured by the ACC Program’s KPI methodology • Inpatient hospital services • Prescription drugs • Office visits
<p>Patient and provider satisfaction</p> <ul style="list-style-type: none"> • Patient satisfaction, as measured using the CAHPS survey • Provider satisfaction, as measured using a survey in development by the Department 	<p>Patient and provider satisfaction</p> <ul style="list-style-type: none"> • Patient satisfaction, as measured using the CAHPS survey • Provider satisfaction, as measured using a survey in development by the Department
<p>Process measures</p> <ul style="list-style-type: none"> • Anti-depression medication management, including: <ul style="list-style-type: none"> ○ Effective acute phase treatment (HEDIS metric) ○ Effective continuation phase treatment (HEDIS metric) • BMI assessment and weight measurement (HEDIS metric) 	<p>Process measures</p> <ul style="list-style-type: none"> • Anti-depression medication management, including: <ul style="list-style-type: none"> ○ Effective acute phase treatment (HEDIS metric) • BMI assessment and weight measurement (HEDIS metric) • Clinic visit within 7 days of discharge from a hospital admission

<ul style="list-style-type: none"> • Clinic visit within 7 days of discharge from a hospital admission • Annual monitoring for patients on persistent medications (HEDIS metric) • Tobacco Use Assessment • Tobacco Cessation Intervention (HEDIS metric) 	<ul style="list-style-type: none"> • Well-child visits in the first 15 months of life (HEDIS metric) • Adolescent well-care visits (HEDIS metric) • Childhood immunization status (HEDIS metric) • Percent of children who have received dental sealants (CMS 416)
<p>Health outcomes measures</p> <ul style="list-style-type: none"> • Asthma admission rate (AHRQ metric) • PQI diabetes, short-term complication admission rate (AHRQ metric) • PQI chronic obstructive pulmonary disease admission rate (AHRQ metric) • PQI congestive heart failure admission rate (AHRQ metric) 	<p>Health outcomes measures</p> <ul style="list-style-type: none"> • Asthma admission rate (AHRQ metric)

2.6.2 This section shall also describe additional measures, as required by the payment model that are appropriate for the general health profile of the population served through the pilot.

2.6.3. Finally, this section shall include a description of the benefit(s) of the model to Medicaid recipients to be served through the pilot, including:

- 2.6.3.1 The enhancement of client experience
- 2.6.3.2 Promotion of client engagement in health care services
- 2.6.3.3 Promotion of client satisfaction with health care services
- 2.6.3.4 Increased focus on client-centered care

2.7 – Implementation

The implementation portion of the evaluation will be based on three components: the administrative and operational feasibility of the proposed pilot; a Work Plan that outlines the necessary steps and timelines for implementation; and letters of support from stakeholders and partners supporting the proposed pilot.

- 2.7.1 In this section of the application, the proposal shall address the following components:
 - 2.7.1.1 Proposals shall provide a description of the following functions related to reimbursement. If the proposed pilot does not involve the RCCO

administering claims or taking on risk, these functions will remain with the Department:

- Claims administration process
- Collection and reporting of encounter data to MMIS
- Administration of the utilization management program

2.7.1.2 Proposals shall include description of relevant information systems, including:

- The current and planned technological infrastructure of the RCCO
- Health information technology (HIT) system support of data collection and sharing
- Additional administrative and/or clinical data to be collected
- How data will be used by the RCCO and the participating providers
- How data will be reported to the SDAC

2.7.1.3 Proposals shall describe how the business structure of the organization will foster communication, cooperation, and alignment with the current ACC Program structure and the Department's other goals and initiatives.

2.7.1.4 Proposals shall describe how the pilot would benefit the Department and/or decrease the state's administrative burden.

2.7.1.5 This section shall include a description of how the proposed model could be sustainable past the end of the pilot and replicable to other regions and/or populations in the state.

2.7.2 In addition, the proposals shall include a Work Plan as an attachment to the application. The Work Plan shall include a timeline and steps for implementation of the pilot, a description of the staffing for administering the pilot for the RCCO and partners (if applicable), and a stakeholder engagement plan that demonstrates how client and community partners were included in the development of the proposal and plans for continued engagement through implementation.

2.7.3 RCCOs may also attach letters of support from stakeholders and partner organizations. To the degree to which the proposal is dependent upon community and partner support, these letters will be considered in the evaluation process.

Proposals that include the consolidation of existing PCCM or managed care programs into the ACC Program structure or that otherwise reduce administrative burdens on the Department will be given preference.

EVALUATION PROCESS

The evaluation of proposals will result in a recommendation for award of the Contract. The award will be made to the Offeror(s) whose proposal, conforming to the solicitation, will be most advantageous to the State of Colorado, best price, and other factors considered.

The Department will conduct a comprehensive, thorough, complete, and impartial evaluation of each proposal received.

Department Review

An Evaluation Committee will be established to score the weighted sections of the proposals. In addition, each of the minimum requirements will be assessed by subject matter expert staff in the Department and other state agencies. The Evaluation Committee may also be supported by staff when subject matter expertise is necessary.

The selection of the committee members will utilize measures to ensure the integrity of the evaluation process. These measures include the following:

- Selecting committee members who do not have a conflict of interest regarding this solicitation.
- Facilitating the independent review of proposals.
- Requiring the evaluation of the proposals to be based strictly on the content of the proposal.
- Ensuring the fair and impartial treatment of all Offerors.

The objective of the Evaluation Committee is to conduct reviews of the proposals that have been submitted, to hold frank and detailed discussions among themselves, and to recommend an Offeror(s) for award.

State agency staff who are selected as subject matter experts will evaluate proposals to determine if each Offeror met all mandatory minimum requirements. The mandatory minimum requirements are scored on a Met/Not Met basis and only those proposals found to meet all mandatory requirements can be considered for a Contract resulting from this solicitation.

After the Subject Matter Experts evaluate the mandatory minimum components of each application, proposals will then be evaluated by the Evaluation Committee using the evaluation criteria outlined in this document. Evaluation criteria may be weighted to reflect the relative importance of the criterion. The number of points given for each criterion will be based on the evaluator's assessment of the response including whether all critical elements described in the solicitation have been addressed, the capabilities of the Offeror, the quality of the approach and/or solution proposed, and any other aspect determined relevant by the Department. Scores for all evaluators will be multiplied by the weighting, if specified, to determine the number of points.

The Evaluation Committee may, if it deems necessary, request clarifications, conduct discussions or oral presentations, or request best and final offers. The Evaluation Committee may adjust its scoring based on the results of such activities. However, proposals may be reviewed and determinations made without such activities. Further opportunity for explanation might not exist; therefore, it is important that proposal submissions are complete.

Compliance

It is the Offeror's responsibility to assure that Offeror's proposal is complete in accordance with the direction provided within all solicitation documents. Failure of an Offeror to provide any required information and/or failure to follow the response format set forth in Appendix A, Administrative Information, may result in the disqualification of the proposal.

Proposal Scores

The recommendation for an award from this solicitation will be determined by an Evaluation Committee through the use of a scoring system that combines three scores: the **Application** score, the **Diversity** score, and the **Operational Flexibility** score.

<i>Scored Component</i>	<i>Possible Points</i>
Diversity <ul style="list-style-type: none">• Geography• Populations• Pilot Approach	3.00
Operational Flexibility	2.00
Application	10.00
Overall Score for Proposal	
	15.00

Diversity Score

The Department is required to award one (1) pilot but may consider awarding more than one (1). If the Department is able to award more than one pilot, the proposals will be evaluated comparatively based on the diversity between them. The factors included in this consideration include diversity in geography, pilot populations, and the proposed models or approaches.

Operational Flexibility

In addition, proposals may be evaluated based on the operational flexibility of the proposal and the Offeror. For example, if the proposal includes a component that is operationally challenging, but a change to that component would not alter the ability to meet the project's goals and to maintain integrity with the overall approach, the proposal would be considered flexible. These determinations may be made through requests for clarification or discussions with the Offeror.

Application Sections

If Subject Matter Experts determine that all minimum requirements are met, the Evaluation Committee will evaluate each proposal separately by scoring the component sections of the application. Sections are weighted and compiled into an Application Score using the following weights:

Application Score		
Section		Weight
0.0	Letter of Intent	5%
1.0	Minimum Requirements	Met/Not Met
2.0	Proposal Description	
2.1	Payment Methodology	5%
2.2	Policy Innovation	20%
2.3	Cost Savings	10%
2.4	Population and Geography	15%
2.5	Provider Network and Structure	15%
2.6	Health Outcomes and Client Centeredness	15%
2.7	Implementation <ul style="list-style-type: none"> • Administrative and Operational Feasibility • Work Plan (Attachment) • Letters of Support (Attachment) 	15%
Application Score <i>(10.00 points possible)</i>		100%