STATE OF CONNECTICUT

OFFICE OF HEALTH STRATEGY

REPOSTING - REQUEST FOR PROPOSAL (RFP)

FOR

DATA ANALYTIC SERVICES FOR COST GROWTH BENCHMARK AND PRIMARY CARE TARGET INITIATIVE AND OHS ANALYTIC NEEDS

Updated Dates

The Office of Health Strategy (OHS) is reposting the existing RFP for the Data Analytic Services for Cost Growth Benchmark and Primary Care Target Initiative and OHS Analytic Needs. This was necessary as OHS received an extensive list of questions requiring significant additional time to respond. This review and response process inadvertently resulted in the submission period of July 12, 2021 expiring prior to the completion of OHS' response.

This reposted RFP includes an adjusted timeframe and the previously issued addendums containing answers to respondent questions. These are the only changes to the RFP. There were no changes to any other sections.

The responses to remaining questions will be posted as an addendum no later than Friday, July 16.

- If you review the addendum and decide there are no changes to your proposals, you do not need to revise your proposals submitted on or before July 12, 2021. We will keep the original proposal as part of the bidding process.

- If you review the addendum and decide to revise your original submission, you are welcome to re-submit your proposals on or before July 28, 2021.

UPDATE: The submission due date is changed to **July 28, 2021**

Applicable Dates:

Request for Proposals Release Date	**June 9, 2021**
Deadline for Respondent Questions	**June 23, 2021**
Deadline for Answers to Questions	**June 25, 2021***
Application Due Date:	**July 28, 2021 by 3:00 pm**
Anticipated Issuance of Notice of Award:	**August 18, 2021**
Anticipated Period of Performance:	**September 15, 2021 to August 31, 2026**

*Because the deadline for answers to questions was not met, the RFP is being reposted as described above.

STATE OF CONNECTICUT
OFFICE OF HEALTH STRATEGY

REQUEST FOR PROPOSALS (RFP)
DATA ANALYTIC SERVICES FOR HEALTH CARE BENCHMARKS and PRIMARY CARE TARGET INITIATIVE AND OHS ANALYTICS NEEDS

The Office of Health Strategy ("OHS" or "Office") is seeking a contractor with expertise in advanced health data analytics to provide analytic services for health data including the OHS All-Payer Claims Database (APCD), Hospital Discharge Database, Outpatient Surgical Center Database, Hospital Reporting System, and other publicly available data sets for ongoing support and monitoring of Connecticut's health care benchmarks and primary care target initiative, OHS analytic projects and data use strategy. Additionally, the contractor should provide an option for an Azure cloud-based analytic solution using OHS data as part of the scope, but the priority for this proposal is the analytic services.

Scope of Services

A. STATEMENT OF OBJECTIVES

The Office is publishing this Request for Proposal (RFP) for advanced health data analytics services and possibly an Azure cloud-based solution. As part of implementing the Governor's Executive Order No. 5 (EO5), a.k.a. Health Care Benchmarks and Primary Care Target Initiative, and meeting additional analytics needs of the office, which may include, but not be limited to, updating the Connecticut Healthcare Affordability Index (CHAI) and supporting the Office's data use strategy, OHS requires a contractor experienced in advanced health data analytics that enables analyses of in-house databases and other data described above. There may also be the option to incorporate an Azure cloud-based analytic solution using OHS data for staff to use and maintain the data.

B. DELIVERABLES

The deliverables for this project include, but may not be limited to:

- Development of analytical tools for:

- Tracking trends in costs, cost drivers, service pricing variability among healthcare providers, market concentration, and conditions of care with a standard set of reports.
- Ongoing monitoring of health care cost growth, quality, and primary care spending.
- Statistical modeling of healthcare policy initiatives using the CHAI. Identifying cost stratified by social risk factors including income, race/ethnicity, geographic region, and language.
- Ad hoc analyses to support other OHS data use strategy for regulatory, policy, and program objectives and decision making, (e.g. Top 10 outpatient prescription drug by spend based on statutory criteria, COVID claims monitoring).
- Web-based reports and dashboards including a cost estimator, online consumer health services pricing tool based on OHS statutory criteria.

- Leveraging cloud-based, enterprise-grade solutions, platforms and services that have widespread adoption, scale easily and are cost-effective to acquire, implement and maintain.

This is a competitive procurement. The procurement is expected to result in a five-year contract.

The contract period will commence on or about September 15, 2021 and expire on August 31, 2026, with two one-year extensions at the option of OHS.

A qualified vendor ("Contractor") will be an organization experienced in providing cloud-based advanced data analytic solutions.
The State may modify the RFP prior to the deadline for submittals by issuance of an electronic addendum on following website:

https://portal.ct.gov/DAS/CTSource/CTSource

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1 EXECUTIVE SUMMARY

The Office of Health Strategy was established by the Connecticut General Assembly in 2018. The mission of OHS is to implement comprehensive, data driven strategies that promote equal access to high quality health care, control costs and ensure better health for the people of Connecticut. As part of implementing the Governor's Executive Order No. 5 (EO5), a.k.a. the Health Care Benchmarks and Primary Care Target Initiative, OHS requires a contractor experienced in advanced health data analytics to provide analytic services using OHS data such as the APCD, hospital discharges, outpatient surgical center, and hospital financial data and other publicly available data sets for ongoing support and monitoring of Connecticut's health care benchmarks and primary care target initiative, other analytic projects, and data use strategy. OHS also requires the contractor experienced in cloud-based architecture to provide an option to develop a Azure cloud-based analytic solution using OHS data, however the advanced health data analytic reporting is the primary deliverable.

Any questions related to this should be directed to:

Krista Moore, Principal Health Care Analyst, Office of Health Strategy, Healthcare Innovation:
krista.moore@ct.gov

Applications must be submitted electronically on or before date at 3pm to krista.moore@ct.gov

RFP Name	Data Analytics Services
RFP Release Date	June 9, 2021
Electronic Location of Request for Proposals	https://portal.ct.gov/DAS/CTSource/CTSource
Request for Proposals Application Due Date	July 28, 2021
Anticipated Notice of Award	August 18, 2021
Period of Award	September 15, 2021 to August 31, 2026
Anticipated Number of Awards	1
Eligible Applicants	1

2 BACKGROUND INFORMATION

2.1 OFFICE OF HEALTH STRATEGY

The Office of Health Strategy was established by the Connecticut General Assembly in 2018. The mission of the Office is to implement comprehensive, data driven strategies that promote equal access to high quality health care, control costs and ensure better health for the people of Connecticut. Under section 19a-754a (and other sections of the general statutes), the Office is charged with, among other duties:

1) Developing and implementing a comprehensive and cohesive health care vision for the state, including, but not limited to, a coordinated state health care cost containment strategy.
2) Promoting effective health planning and the provision of quality health care in the state in a manner that ensures availability of and improved access to cost-effective health care services for all state residents.
3) Directing and overseeing the State Innovation Model Initiative and related successor initiatives.
4) Coordinating the state's health information technology initiatives, administration of the all-payer claims database program, establishing and maintaining a consumer health information web site, designating a health information technology Officer; and
5) Directing and overseeing the Health Systems Planning Unit.

OHS develops health policy that improves health outcomes and limits health care cost growth across all sectors, whether private or public, including hospitals, physicians, clinical services, prescription drugs and medical devices and supplies. Creation of this Office brought together critical data sets and health information exchange efforts and allows for collaboration with many stakeholders, including state agency partners. Working with comprehensive data and experts from inside and outside government, OHS will develop and support state-led multi-payer health care reforms.

Connecticut faces an urgent need to slow the growth in healthcare costs. The historical growth rate in healthcare costs in the State is unsustainable; Connecticut is in the top tier of healthcare spending nationally.[1] In 2014, Connecticut's per capita spending on personal health care was $9,859 – the fifth highest in the nation, outpaced only by Vermont, Delaware, Massachusetts, and Alaska. Over the last two decades, annual healthcare spending in Connecticut grew at more than twice the rate of growth in median household income (4.8 percent versus 2.0 percent).[2] Consequently, healthcare has become unaffordable to many Connecticut residents and employers. Since 2000, employer-sponsored insurance premiums in Connecticut have grown two and a half times faster than personal income. This growth in premiums and in healthcare costs generally make it difficult for business to compete and thrive in Connecticut, which in turn leads to reduced worker wage growth.

These effects of Connecticut's high healthcare costs are felt by all Connecticut residents, but especially those with low and modest wages. Connecticut has a higher household income distribution inequality than most other states, falling behind only Puerto Rico, the District of Columbia and New York when measuring household income distribution inequality by looking at average income wages across the State.[3] The economic effects of COVID-19 has heightened the strain of cost growth. Connecticut ranks last among all states in terms of personal income growth during the pandemic.[4]

A 2019 study by the Robert Graham Center found that Connecticut spends the least of any state in the United States on a per capita basis on primary care as a percentage of health care expenditures in one definition and is in the middle of the pack using a narrower or broader definition. A 2020 study by the New England States Consortium Systems Organization (NESCSO) also found that, using the narrow definition, Connecticut's commercial payers' primary care spending as a percentage of health care

[1]Personal health care spending, per capita, by state. Centers for Medicare and Medicaid Services, State Health Expenditure Accounts, 2014.
[2] Medical Expenditure Survey, Tables D.1 and D.2 for various years.
[3] US Census Bureau, September 2019.
[4] *The Connecticut Mirror*, "Connecticut ranks last in personal income growth over past year," November 11, 2020.

expenditure is 5.3%, middle of the pack, and higher than Medicare Advantage's (4.7%) and Medicare Fee-for-Service's (2.8%), which were also the lowest in New England.[5] The narrow definition excludes office-based and outpatient visits to obstetrics and gynecology, nurse practitioners, physician assistance and behavioral health services.

Further, Connecticut continues to rate well in most national reports on health care, yet such reports continue to mask significant health disparities across the state. In particular, a 2020 Connecticut Health Foundation report found disparities such as: newborn black babies are four times more likely to die within a year of birth compared to their white peers; black residents are four times more likely to have a diabetes-related lower extremity amputation and twice more likely to die from diabetes as their white peers; black and Hispanic children and teens are five and one-half and four and one-half times, respectively, more likely than their white peers to visit the emergency department because of asthma; and black men are more likely than white men to die from prostate cancer. Additionally, a 2019 Kaiser Health News quality report indicates that all but one hospital in Connecticut were penalized by the Centers for Medicare and Medicaid Services for thirty-day readmissions. Connecticut's health care quality must improve across clinical quality measures and other measures of low-value care and patient safety.

http://portal.ct.gov/ohs

2.2 HEALTH CARE BENCHMARK INITIATIVE

A. EXECUTIVE ORDER NO. 5

To address rising healthcare costs the need to better resource primary care and the need to improve healthcare quality, on January 22, 2020 Governor Lamont signed Executive Order 5 to establish a statewide healthcare cost growth benchmark. The Executive Order directs the Office of Health Strategy (OHS) to develop annual healthcare cost growth benchmarks for calendar years (CY) 2021-2025, and to implement several additional, related initiatives.

1) The Executive Director of OHS, consistent with her statutory authority, shall monitor health care spending growth across all public and private payers and populations in Connecticut, report annually to the Governor on such growth, and, by December 2020, develop annual health care cost growth benchmarks.
2) The Executive Director of OHS shall develop such initial annual benchmarks for calendar years 2021 through 2025.
3) The Executive Director, pursuant to her statutory authority under CGS Section 4-8, shall convene a Connecticut Cost Benchmark Technical Advisory Board to assist her in developing such benchmarks. The members of that Technical Advisory Board shall be named within the next thirty days and include the Secretary of the Office of Policy and Management and the Commissioners of the Department of Social Services and the Insurance Department, or their designees, and representatives of health care stakeholders.

[5] Connecticut's Medicaid APCD data was not sufficiently complete for inclusion in the analysis.

4) Such health care cost benchmarks shall be based on total health care expenditures, defined as the per capita sum of all health care expenditures in this state from public and private sources for a given calendar year.
5) Such health care cost growth benchmarks shall account for current primary care spending and set targets within each annual benchmark for increased primary care spending as a percentage of total health care expenditures to reach a target of 10% by calendar year 2025.
6) To ensure the maintenance and improvement of healthcare quality, the Executive Director of OHS, with the input and assistance of the Commissioners of the Department of Social Services, the Department of Public Health, and the Insurance Department, shall use the existing OHS Quality Council to assist in the development of quality benchmarks across all public and private payers beginning in calendar year 2022. Such quality benchmarks may include clinical quality measures, under- and over-utilization measures, and patient safety measures.

Benchmarks and primary care spending targets must account for the significant health care disparities in access and outcomes in Connecticut and should ensure that development of such benchmarks aims toward elimination in such disparities.

The following paragraphs provide brief descriptions of the approach OHS will take to implement Executive Order 5.

B. HEALTHCARE COST GROWTH BENCHMARK

The healthcare cost growth benchmark is a targeted annual per capita maximum rate of spending growth that payers, providers, and the State are expected to adhere to. The benchmark is based on a calculated and pre-determined weighted blend of the growth in the forecasted per capita potential gross state product (PGSP), and the forecasted growth in median income with a two-year add-on factor. The forecasted per capita PGSP for Connecticut is 3.7%. The forecasted median household income growth for 2026 – 2030 in Connecticut is 2.7%. **Table 1** below presents the Benchmark for 2021-2025. Performance against the benchmark will be reported at the State level, the market level, the payer level (including state payers), and provider organization level for provider organizations that have a sufficient number of attributable lives.

Table 1. Healthcare Cost Growth Benchmark Values 2021-2025 Calendar Year	**Cost Growth Benchmark Values**
2021	3.4%
2022	3.2%
2023	2.9%
2024	2.9%
2025	2.9%

C. PRIMARY CARE SPENDING TARGET

The primary care spending target aims to strengthen Connecticut's primary healthcare services system by establishing a goal for increasing statewide primary care spending as a percentage of total health care expenditures; the target reaches 10 percent by Calendar Year 2025. Research has demonstrated that greater relative investment in primary care leads to better patient outcomes, lower costs, and improved patient experience of care.[6] Like most of the country, Connecticut's healthcare system is largely specialist oriented. This target is intended to rebalance and strengthen the State's healthcare system by supporting improved primary care delivery.

The primary care spending target for calendar year 2021 is 5.0 percent, using OHS' definition of primary care spending. It is conservative given that the current best estimate of statewide spending on primary care is 4.8 percent. OHS calculated a statewide weighted average of current primary care spending by total medical expenditures utilizing commercial and Medicare data from UConn and Medicaid data from Freedman Healthcare, and the Department of Social Services. OHS' advisory bodies recommended setting a conservative target for the first year of the Target due to the lack of payer-reported baseline data, utilization changes occurring due to COVID-19, and the proximity of the 2021 measurement period limiting payer actions to increase primary care spending in 2021.

OHS will establish primary care spending targets for calendar years 2022-2024 in late 2021, after receiving guidance from its advisory bodies. Performance against the primary care target will be reported at the State, market, payer, and provider organization levels, in the same manner as the cost growth benchmark reporting.

D. QUALITY BENCHMARKS

OHS will develop quality benchmarks across all public and private payers beginning in 2022, including clinical quality measures, over/under utilization measures, and patient safety measures.

OHS' advisory body for the quality benchmarks, the CT Quality Council, is working to recommend a core measurement set for assessing primary care, specialty, and hospital provider performance and a common provider scorecard format for all payers and across the health ecosystem to align meaningful metrics and reduce the burden of repetitive or non-comparable analyses for the purposes of delivery and payment models that account for quality performance at the provider organization level. Subsequent to the updating of the core measure set, the Council will select a set of quality benchmarks that may include the core measures and population health measures that would be reported for the purposes of EO5 and applied similarly to the cost growth benchmark and primary care target, at the State, market, payer and provider organization levels.

[6] Starfield B, Shi L, Macinko J. "Contribution of primary care to health systems and health." *Milbank Q*. 2005;83:457–502, and Chernew M, Sabick L, Chandra A, Newhouse J. "Would having more primary care doctors cut health spending growth?" *Health Affairs* (Millwood) 2009; 28(5):1327–35.

E. DATA USE STRATEGY

Governor Lamont's Executive Order 5 calls upon OHS to monitor and report "annually on healthcare spending growth across public and private payers." OHS uses the term "data use strategy" to refer to its plan to purposefully leverage state and other publicly available data to achieve these objectives. OHS will use the APCD and other publicly available data, including internal and external sources, to make sure the aims of the Executive Order and other policy objectives of the Office and the State are achieved. By analyzing data, OHS can identify which spending categories warrant greatest attention for "moving the needle" on the cost growth benchmark. The following types of analyses will be prioritized by OHS as part of its data use strategy consistent with the recommendations of its advisory bodies:

1) analyses that identify the leading factors contributing to year-over-year health care cost growth (e.g., changes in utilization, price, service mix/intensity, patient demographics*);
2) analyses that examine which cost drivers most contribute to total cost of care at a point in time (e.g., specific services, provider types, providers, medical conditions); and
3) analyses of the effects of the cost growth benchmark, including any unintended consequences that may arise from its implementation.

*OHS expects analyses to be stratified by race and ethnicity to address longstanding disparities. Patient demographic categories may be expanded as data collection becomes more robust.

3. REQUIRED SERVICE COMPONENTS AND SCOPE OF WORK

CURRENT WORK AND RECOMMENDATIONS

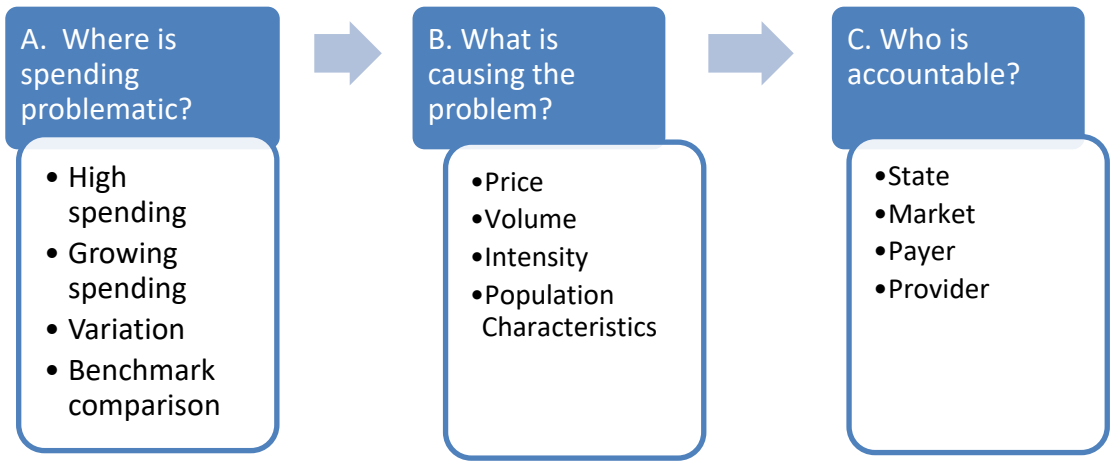
OHS' current data analytic vendor has completed and presented the results of the initial analyses listed in the analytic framework below, utilizing the CT All Payer Claims Data (APCD) data. The framework and recommendations for deeper analyses are shown below as extensions:

Analytic framework

Domain	Initial work, 2020	Extensions
Sample	Commercial	Medicaid, Medicare
Types of claims	Medical	Pharmacy, dental
Complexity	Simple	More complex
Focus areas	Spending (Total, PMPM, change over time, OOP) Spending by category of service Utilization and spending per unit Out-of-pocket spending Chronic conditions	Avoidable hospital use Low value services Market concentration Quality Price variation
Stratifications and data enrichment	Demographic groups (age and gender), region, payer, populations defined by presence of chronic condition	Provider groups Episodes of care Adjust spending for medical risk Social determinants of health
Opportunities	Regions, populations, services, and/or conditions driving costs	More specific services and trends Variation among providers in practice patterns and spending
Actionability	Descriptive, background, establish trust in data Identify initial set of cost drivers & opportunities to reduce costs	More complex, specific, controversial, and actionable topics possible Identify more specific drivers and opportunities Promote accountability

The framework for the data use strategy analyses is as follows:

Figure 1. Framework for Data Use Strategy Analyses



3.1 Advanced Analytics with Visualizations

The initial analyses could run concurrently with development of a long-term solution.

The successful Respondent will link and analyze OHS historical and current APCD, hospital patient, and financial data, and other data such as US Census and Centers for Medicare and Medicare Services data, for:

1) Ongoing monitoring of health care cost growth, quality, and primary care spending.
2) Identifying trends in costs, cost drivers, service pricing variability among healthcare providers, market concentration, and conditions of care.
3) Identifying and measuring cost stratified by social risk factors including income, race/ethnicity, geographic region, and language.
4) Measuring and tracking unintended consequences of the benchmark initiative and recommending and implementing effective mechanisms for filling any data gaps required for successful implementation and ongoing management of the initiative.
5) Statistical modeling of healthcare policy initiatives using the Connecticut Healthcare Affordability Index (CHAI).
6) Reporting on the OHS' quality benchmark.
7) Reviewing data analyses provided in other states implementing a similar initiative and developing comparable relevant analyses for Connecticut.
8) Creating standard reports and interactive dashboards for analytic results for web-posting
9) Ad hoc analyses to support other OHS regulatory, policy, and program objectives and decision making as described above (e.g., COVID impact on health care services utilization and spending.

The successful Respondent will also:

1) Collaborate with OHS and other consultants involved in implementing the initiative.
2) Present findings of analyses to stakeholders, advisory bodies, and consumers
3) Provide knowledge transfer to OHS analysts for continued data analytics support for the initiative.

3.2 OPTION WITH BUSINESS SOLUTION

The successful Respondent shall develop and train OHS staff to maintain an Azure cloud-based analytic solution which preserves and protects any protected health information data from unauthorized access and complies with all state and federal requirements regarding security of such data. Additionally, the Respondent will:

1) Utilize OHS data including but not limited to the APCD, hospital inpatient and outpatient surgery and financial data and other publicly available healthcare and/or demographic data such as from US Census, Centers for Medicare and Medicaid Services Chronic Conditions Data Warehouse, National Committee for Quality Assurance, US Health and Human Services measurement metrics and data.
    a. OHS data includes historical (2012-2020) and future claims, patient encounter and hospital information, and
    b. OHS data is refreshed annually (patient and financial) and quarterly (claims)
    c. Average number of records per year in claims data is about 37 million; hospital inpatient discharge data about 400,000; outpatient surgery is about 360,000 records; hospital financial data contains about 500,000 records. For more information about OHS databases check out the OHS Data Compendium on the OHS website.

2) Develop and implement the data governance for the solution to provide role-based access to data and analytic results to OHS leadership, analysts, and consumers (or the public)
3) Merge the data into a single unified data architecture to facilitate analyses.
4) Develop standard and automated analytic reports and visualizations within the solution.
5) Develop monthly or quarterly analytic reporting customized to meet OHS's specific needs.
6) Develop sufficient analytic tools and provide technical training to enable OHS analysts to independently monitor healthcare cost and performance trends across plans, payers, and populations, and to support OHS operations.
7) Develop tools to enable OHS to monitor payments and track performance for provider groups engaged in value-based payment arrangements with the state or its partners.
8) Provide related computer programming and analytic codes and technical training to enable OHS analysts to independently maintain and update analytic solution.

The levels of analysis may include the following:

Level of Analysis	Categories	Potential Subcategories
State	N/A	Region, county, city, zip code
Market	• Commercial • Medicaid • Medicare	Commercial fully insured, commercial self-insured, marketplace, Medicaid managed care, Medicaid fee-for-service, Medicare Advantage, traditional Medicare
Payer	Individual payer by market	Commercial payer product (e.g., HMO, PPO, EPO, other)
Provider Entity	N/A	Practice/practice site, facility,[i] clinician and facility specialty type, site of service

Standard reports may include but are not limited to:

Report #	Report Description	Drill Down of Spend/ Growth Trend
1	Spend by Market (PMPM)	None
2	Trend by Market (per capita)	price, volume, intensity
3	Spend by Geography (PMPM)	price, volume
4	Trend by Geography	price, volume, intensity
5	Spend by Service Category	price, volume
6	Trend by Service Category	price, volume, intensity
7	Spend by Health Condition	price, volume
8	Trend by Health Condition	price, volume, intensity
9	Spend by Demographic Variables	price, volume
10	Trend by Demographic Variables	price, volume, intensity
11	Cost Growth Target Unintended Consequences	N/A

Categories of health services from the National Health Expenditure Accounts

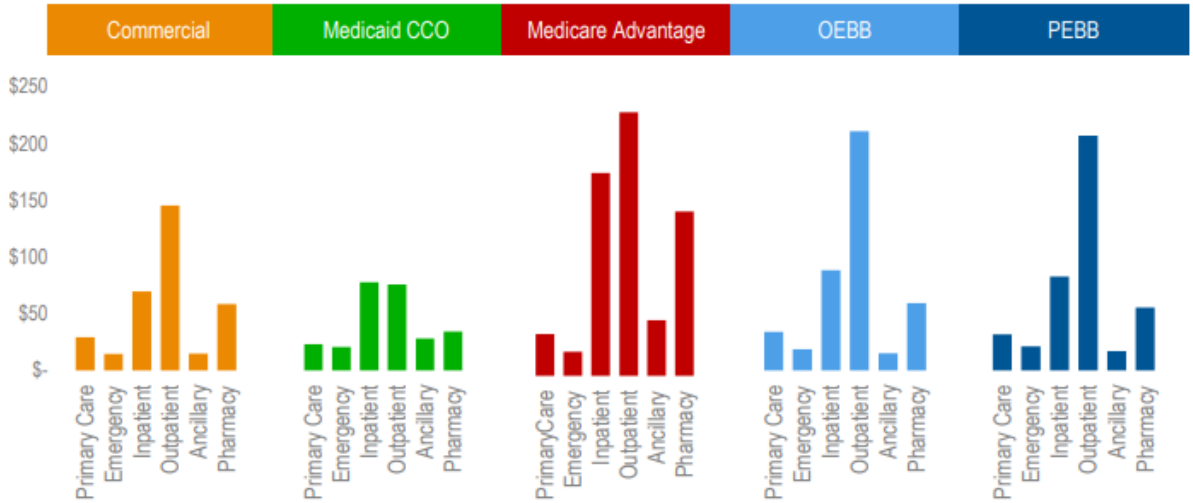
Category/Subcategory	Description
1. Hospital care	Services provided by hospitals to patients, including room and board, ancillary charges, services of resident physicians, inpatient pharmacy, hospital-based nursing home and home health care, and any other services billed by hospitals
a. Inpatient hospital care	*New subcategory that is not included in the original NHEA framework
b. Outpatient hospital care	*New subcategory that is not included in the original NHEA framework
c. Other hospital-based care	*New subcategory that is not included in the original NHEA framework
2. Professional services	
a. Physician and clinical services	Services provided by MDs and DOs, and by outpatient care centers (e.g., FQHCs, RHCs)
i. Primary care	Spending associated with primary care-specific provider taxonomy codes[ii] *New subcategory that is not included in the original NHEA framework
ii. Specialty care	Spending associated with specialty care-specific provider taxonomy codes[iii] *New subcategory that is not included in the original NHEA framework
b. Other professional services	Services provided in establishments operated by health practitioners other than physicians and dentists (e.g., private-duty nurses; chiropractors; podiatrists; optometrists; physical, occupational and speech therapists)
c. Dental services	Services provided in establishments operated by a DMD, DDS or DDSc
3. Other health, residential and personal care services	Spending for home and community-based Medicaid waivers, residential care facilities, ambulance services, school health, and worksite health care
a. Home and community-based waivers	*New subcategory that is not included in the original NHEA framework
b. Residential care facilities	*New subcategory that is not included in the original NHEA framework
c. Other subcategories defined by the state's Medicaid program	*New subcategory that is not included in the original NHEA framework
4. Home health care	Medical care provided in the home by freestanding home health agencies
5. Nursing care facilities and continuing care retirement	Nursing and rehabilitative services provided in freestanding nursing home facilities
a. Subacute nursing facilities	*New subcategory that is not included in the original NHEA framework
b. Rehabilitative services	*New subcategory that is not included in the original NHEA framework
c. Long-term care	*New subcategory that is not included in the original NHEA framework
d. Assisted living	*New subcategory that is not included in the original NHEA framework
6. Pharmaceutical spending	Spending for human-use dosage-form prescription drugs, biological drugs, or vaccines *Modified to exclude diagnostic products that are available only by a prescription
a. Brand name drugs	*New subcategory that is not included in the original NHEA framework
b. Generic drugs	*New subcategory that is not included in the original NHEA framework
c. Specialty drugs	Drugs with a 30-day equivalent negotiated price of $670 in 2020 and $780 in 2021[iv]

Category/Subcategory	Description
	*New subcategory that is not included in the original NHEA framework
d. Physician-administered drugs	Distinguished by the use of a "J code" on medical claims. Sometimes referred to as "medical pharmacy." *New subcategory that is not included in the original NHEA framework
7. Durable medical equipment	Spending on items such as contact lenses, eyeglasses, surgical and orthopedic products, hearing aids, wheelchairs, and medical equipment rentals
8. Other	All other spending not captured in the categories above (e.g., laboratory facilities, imaging facilities, freestanding surgical centers) *New category that is not included in the original NHEA framework

* Represent modifications from the National Health Expenditure Accounts framework.

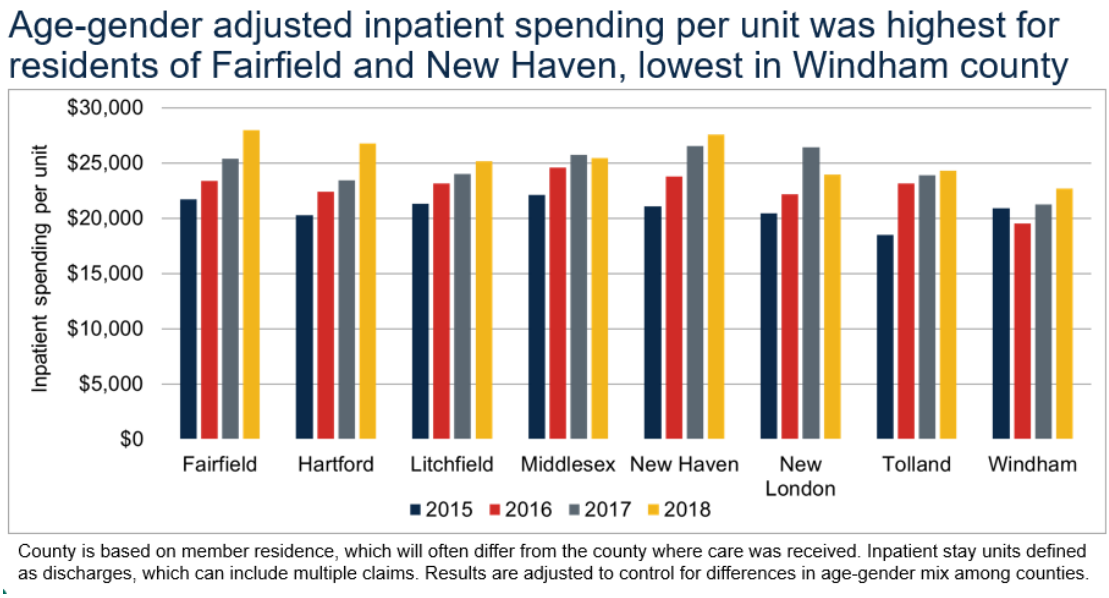
Examples of visualizations include:

Figure 1. Oregon Health Authority Assessment of Spend by Service Category



Source: Oregon Health Authority. (2015, April 30). Leading Indicators for Oregon's Health Care Transformation: Quarterly Data from the All-Payer, All-Claims Reporting Program. Retrieved February 24, 2021, from https://www.oregon.gov/oha/HPA/ANALYTICS/APAC Page Docs/Leading-Indicators-Report-April-2015.pdf.

Figure 2. Spend and Trend by Geography Example from the Connecticut Office of Health Strategy Assessment



Source: Connecticut Office of Health Strategy. (2021, January 21). *CT Commercial Cost Trends*. Analysis of the Connecticut commercial market performed by Mathematica.

3.3 Other Requirements

3.3.1 Qualifications

The successful Respondent must possess and demonstrate the following:

Health Care Analytics/Reporting

1) Expertise in health care analytics.
2) Expertise in analyzing health care claims data.
3) Expertise in building a modern, cloud based integrated data and analytic capability.
4) Experience in predictive modeling by health care sector or broad categories of services.
5) Experience in accounting for underlying contributors to cost in developing such prediction modeling.
6) Experience in quality, trend, financial, statistical, and clinical reporting.
7) Experience managing ad-hoc reporting that goes beyond the regularly scheduled standard reports.
8) Experience in health care quality measures and metrics.
9) Experience in health equity measures and metrics.
10) Familiarity with data reporting and modeling work being performed in support of health care cost growth benchmarks in Massachusetts, Rhode Island, Delaware, and Oregon as well as any primary care and/or quality benchmarks in these states.

11) Expertise contracting with other government agencies to provide services like those the State of CT is seeking.
12) Expertise in presenting analytic results to stakeholders, advisory bodies, and the l public.
13) Expertise in developing web-based analytic reports and interactive dashboards
14) Expertise merging data, including big data and health care claims data, from different sources into a single unified data and analyzing such data.
15) Expertise in receiving and synthesizing administrative claims data and reporting clinical data, for the purpose of measuring quality, primary care target, and cost growth and equity. Expertise in transferring built analytic solution to client to operate effectively and continuously.

3.4 KEY OUTPUTS AND TIMELINE

The following table lists high-level outputs associated with the required scope of work for the contract. The applicant will also be responsible for the milestones and timelines it submits as part of their proposal. The applicant should assess the below timeline and propose modifications based on its own subject-matter expertise.

The initial analysis could be running concurrently with development of a long-term solution.

Priority 1 and 2 will be running concurrently, as the applicant will need to create the reports in priority 2 from data provided by OHS, while developing the cloud-based infrastructure in priority 1.

EXHIBIT 1: KEY OUTPUTS AND TIMELINE GRID

Priority	Key Milestones	Timeline
1.	Create and provide 3 standard cross-market cost reports per quarter. Work with OHS and its consultants to determine three standard reports for identifying cost drivers, and tracking cost trends, pricing variability among providers, market concentration, conditions of care, and primary care.	January, April, September, December annually
2.	With Business Solution Option – Develop cloud-based Azure solution. Activities include – 1. Execute any necessary security, data use, or other agreements with OHS. 2. Create solution design and data governance.	Month 6 – 8, Year 1 only.
3.	Create and provide 4 additional reports over 12 months. Work with OHS and its consultants determine four additional standard analytic reports to identify costs of categories of healthcare services stratified by social risk factors – income, race/ethnicity, geographic region, and language	December 2023
4.	Work with OHS and consultants to develop standard data analyses for measuring and monitoring unintended consequences of implementing the benchmark initiative	December 2022

5.	Present findings of analyses to OHS staff, consultants, stakeholders, advisory bodies, and the public as OHS requests	Ongoing quarterly
6.	Work with OHS and consultants on data collection, calculation, analytics, and reporting tasks associated with OHS' Quality Benchmark	June 2022
7.	Update and maintain statistical modeling of healthcare policy initiatives using the CT Healthcare Affordability Index (CHAI) with the assistance of OHS and consultants	September 2021 and annually thereafter
	Develop reports and interactive dashboards for web posting, including but not limited to: 1. Cost estimator/healthcare services pricing tool with OHS guidance 2. Top ten outpatient prescription drugs with significant impact on state expenditures that have experienced price increases based on specific CT statutory criteria, 3. COVID claims monitoring	September – December 2021, and annually thereafter
	Work with OHS to identify and create analytic tools to enable ad hoc analyses to evaluate policy and to support OHS regulatory, policy, and program objectives. Bidder will provide well documented analytic programming code and technical assistance to OHS staff.	
	Provide training and knowledge transfer to OHS analysts for continued data analytics support for the initiative and OHS operations. Bidder will provide direct code to OHS staff.	Ongoing
	Provide ongoing analytic support services as directed	Ongoing

4 AWARD INFORMATION

4.1 AWARD AMOUNT

To be determined between the applicant and the agency.

4.2 ELIGIBILITY INFORMATION

To be eligible, the applicant must be recognized as a single legal entity by the state where it is incorporated and must have a unique Taxpayer Identification Number (TIN) designated to receive payment. Applications will be screened to determine eligibility for further review using criteria detailed in this RFP and in applicable law.

4.3 Period of Performance

The anticipated Period of Performance is listed below:

Applications must be submitted electronically on or before date at 3pm to krista.moore@ct.gov

RFP Name	Data Analytics Services
RFP Release Date	June 9, 2021
Electronic Location of Request for Proposals	https://portal.ct.gov/DAS/CTSource/CTSource
Request for Proposals Application Due Date	July 28, 2021
Anticipated Notice of Award	August 18, 2021
Period of Award	September 15, 2021 to August 31, 2026
Anticipated Number of Awards	1
Eligible Applicants	1

4.4 Termination of Award

Funding is dependent on satisfactory performance against the scope of work and outputs and a decision that continued funding is in the best interest of the State. Proposals will be funded subject to meeting terms and conditions specified in the resulting Contract and available funds. Awards may be terminated if these terms and conditions are not met. State reserves the right to terminate the Contract for any reason.

4.5 Issuing Office and Contract Administration

The Office of Health Strategy ("OHS") is issuing this Request for Proposal (RFP) and is the only contact in the State of Connecticut (State) for this competitive bidding process. The address of the issuing office is as follows:

Name: Krista Moore
Address: P.O. Box 340308
450 Capitol Avenue MS#51OHS
Hartford, CT 06134-0308
E-Mail: krista.moore@ct.gov

The OHS has designated the individual below as the Official Contact for purposes of this RFP. All communications with the Official Contact must be in writing.

The Official Contact is the only authorized contact for this procurement and, as such, handles all related communications on behalf of the Department. Respondents, Prospective Respondents, and other

interested parties are advised that any communication with any other Department employee(s) (including appointed officials) or personnel under contract to the Department about this RFP is strictly prohibited. Respondents or Prospective Respondents who violate this instruction risk disqualification from further consideration.

Name: Krista Moore
Address: P.O. Box 340308
450 Capitol Avenue MS#51OHS
Hartford, CT 06134-0308
E-Mail: krista.moore@ct.gov

5 APPLICATION DETAILS

5.1 SUBMISSION INSTRUCTIONS

This Request for Proposals serves as the application package and contains all the instructions to enable a potential applicant to apply.

5.1.1 Respondents' Questions

OHS encourages Respondents to submit questions by email (to krista.moore@ct.gov) seeking clarification of the RFP requirements. Questions will be reviewed on an ongoing basis and responses will be posted within 5 business days of receipt. OHS will respond to all questions in one or more official addenda that will be posted to the Department of Administrative Services (DAS) website (http://das.ct.gov/cr1.aspx?page=12).

5.1.2 Submission Requirements

The proposal must be submitted to krista.moore@ct.gov no later than the established deadline listed in the Executive Summary. All documents should be submitted as PDFs, with the exception of the budget (Attachment D), which should be submitted as an Excel spreadsheet.

5.1.3 Format Requirements

In order to ensure readability by reviewers, fairness in the review process, and consistency among applications, each application must follow the following specifications to be reviewed:

- Use 8.5" x 11" letter-size pages with 1" margins (top, bottom, and sides).
- All pages of the Response must be paginated in a single sequence.
- Font size must be no smaller than 12-point
- Follow the page limits as detailed in the next section.

5.2 APPLICATION CONTENT

The application should be written primarily as a narrative with detailed specific actions highlighted to emphasize the proposed activity of the applicant. The applicant should organize their response based on the sections detailed below.

I. PROPOSAL FACE SHEET

See **Attachment A**

II. TRANSMITTAL LETTER (No more than 2 pages)

Written statement that addresses:

- That the Respondent accepts without qualification:
  - Assurances and Acceptance (RFP Section 6.2.9);
  - all Mandatory Terms and Conditions;
- Brief statement outlining experience and qualifications to undertake this project;
- A statement that any submitted response and cost shall remain valid for one hundred twenty (120) days after the proposed due date or until the contract is approved, whichever comes first;
- Evidence of Qualified Entity: The Respondent shall provide written assurance to OHS from its legal counsel that it is qualified to conduct business in Connecticut and is not prohibited by its articles of incorporation, bylaws, or the law under which it is incorporated from performing the services required under any resultant contract.
- Sanction – Disclosure: The Respondent shall provide a statement that attests that no sanction, penalty or compliance action has been imposed on the Respondent within three years immediately preceding the date of this RFP. If the Respondent proposes the use of a subcontractor, each proposed subcontractor must provide the same statement.
- Small, Minority or Women's Business Enterprise: Section 32-9e of the Connecticut General Statutes, superseded by Section 4a-60g sets forth the requirements of each executive branch agency relative to the Connecticut Small Business Set-Aside program. Pursuant to that statute, twenty-five (25%) of the average total of all contracts let for each of the three previous fiscal years must be set aside. OHS requires that the Resultant Contractor make a "good-faith effort" to set aside a portion of this contract for a small, minority or women's business enterprise as a subcontractor. Prospective Respondents may obtain a list of firms certified to participate in the Set-Aside program by contacting the Department of Administrative Services at the DAS website.

III. PROJECT ABSTRACT (1 page, single-spaced)

A succinct description of the proposal, how the funds will be used, and the projected impact.

IV. PROJECT NARRATIVE (3 pages, single-spaced)

The Project Narrative should address how the Respondent will carry out the required service components. The Respondent should organize the narrative in the following bolded sections:

1. Overall project

a. Describe the Respondent's perspective on the work envisioned in this RFP. What is the Respondent's overall model and approach?
b. Describe how the work will be organized and managed.

2. Proposed Approach to Technical Assistance

a. Describe the Respondent's strategy for delivering on each of the objectives outlined in **Section 3. Required Service Components and Scope of Work**.
b. Describe the activities the Respondent will undertake to complete the scope of work.
c. Describe the tools, methods, and subject matter expertise that will be leveraged.
d. How much time will be spent on-site? How much time will be spent using other modes of engagement, e.g., video-conference, webinar, etc.

3. Impact on Project's Goals

a. Describe how the Respondent will ensure the goals of the Healthcare Benchmark Initiative data use strategy and OHS data analytic needs, as detailed in **Section 2.2. ,** are met. What is the impact you hope to achieve through this work, including on the initiative's aims?
b. Describe why the Respondent is a good fit to drive towards these goals.

V. QUALIFICATIONS AND PROJECT MANAGEMENT (2 pages, single-spaced)

(Resumes do not count towards the page limit)

This section should describe the background and experience of the Respondent necessary to carry out this project. The Respondent should organize the narrative in the following bolded sections:

1. Qualifications and Experience

a. Describe the Respondent's overall qualifications and background to carry out a project of this nature and scope. Should include its experience in implementing a similar initiative with other states.
b. Describe the Respondent's content level knowledge relevant to the scope of work with the proposed services outlined in **Section 3. Required Service Components and Scope of Work**.
c. Describe contracts held within the past five years with a scope similar to this one. What did you learn from your successes and failures that you would apply here?

2. References

Provide information for at least three references. Must include brief description of work done, the organization's name, specific contact person name, address, phone number, and e-mail.

3. Organizational and Project Structure

a. Provide an organizational structure of the company indicating lines of authority and detail how this proposed project structure fits within the larger structure of the organization.
b. Describe how the project structure will enable effective implementation.

4. Project Management

a. Explain the staffing and management model of the organization as well as for the specific team who would be working with the OHS.
b. Detail the names of proposed personnel, their proposed role, expertise, functions and time commitments.

c. Include the name of a Project Manager who will serve as a single point of contact for the implementation of the project and who will be available to provide status updates and attend all project meetings at the request of OHS.
d. Provide assurance of the capacity to deploy the required staff and resources to complete the scope of work, including identifying any other current or planned contractual obligations that might have an influence on the Respondent's capacity.
e. Identify and describe the role of any and all subcontractors and subject matter experts. Provide the following for each proposed subcontractor:
   - Legal Name of Agency, Address, FEIN
   - Contact Person, Title, Phone, E-mail
   - Services To Be Provided Under Subcontract

Note: The resultant contractor must receive written approval from OHS for staff changes. These changes must not adversely affect the ability of the Contractor to meet any requirement or deliverable set forth in this RFP and/or the resultant contract.

5. Resumes (limit 2 pages per resume)

Provide resumes for each proposed personnel and subcontractor. The resume shall include contract-related experience, credentials, education, training, and work experience.

6. Project Plan and Timeline

Provide a project plan and timeline for completing proposed deliverables. Provide key activities and outputs, beginning and end dates for each, and the accountable person.

VI. SHOW US YOUR SOLUTION

The agency will either invite selected applicants to meet in Hartford, CT, or to have a virtual demonstration, to demonstrate a prototype that will help to visualize the proposed solution. During the demo, plan to step through configured workflow, elaborate on the design, user experience, agile development process, platforms, and technologies used to develop the prototype. OHS would also like to discuss the overall implementation strategy, recommendations on where to start, long term solution vision, and anything else that will be important to determine best overall value. The demonstration is a critically important opportunity to show the understanding of the reimagination opportunity and objectives, how the solution can meet these needs, and how the process used to develop the prototype correlates to the written proposal. Rather than prescribe specific requirements or workflow to be demonstrated, OHS encourages creativity and insights on the anticipated proposal that address the challenges and objectives identified and will look to have applicants demonstrate the related functionality with the working software. OHS anticipates the demonstration session to be approximately 3 hours, including time for questions. For evaluation purposes, the agency will require access to the prototypes beyond the demo session until the contract is awarded.

VII. COST PROPOSAL (3 pages, single-spaced)

a. Identify all proposed personnel with a corresponding all-inclusive hourly rate of compensation. Estimate the total hours expended for the project, broken down by the following categories:
   i. Advanced Analytics with Visualization (Section 3.1)
   ii. Option with Business Solution (Section 3.2)

b. Identify at the granular level detail all the one-time and recurring cloud costs as part of the proposal for the Azure Cloud based solution (Option with Business Solution Section 3.2)

c. Identify travel costs separately. Provide a narrative explanation to support the proposed budget based on the template in **Attachment C**. Include a total budget proposal for Year 1 and Year 2 of the project.

VIII. STANDARD FORMS

The Respondent shall submit the following standard forms:

- **Procurement Agreement Signatory Acceptance:** Proposal must include a Statement of Acceptance, without qualification of all terms and conditions within this RFP and the Mandatory Terms and Conditions for a PSA contract (with proposal, see Attachment B)
- **Consulting Agreement Affidavit** (with proposal, OPM Ethics Form 5, see section 6.2.11)
- **Affirmation of Receipt of State Ethics Laws Summary** (with proposal, OPM Ethics Form 6)
- **Iran Certification** (with proposal, OPM Ethics Form 7)
- **Gift and Campaign Contributions** (prior to contract, OPM Ethics Form 1, see section 6.2.11)
- **Nondiscrimination Certification Form** (prior to contract, see section 6.2.11)

6 EVALUATION AND SELECTION

This section describes the evaluation criteria for this RFP. The review criteria are based on a total of 100 points allocated across the Project Narrative (50 points), Qualifications and Project Management (30 points), and the Budget Narrative (20 points).

APPLICATION PACKAGE	Points
I. Proposal Face Sheet	**Required**
II. Transmittal Letter	**Required**
III. Project Abstract	**Required**
IV. Project Narrative	
V. Organizational Qualifications and Project Management	

VI. Budget Narrative	
VII. Standard Forms	**Required**
GRAND TOTAL	**100**

6.1 REVIEW AND SELECTION PROCESS

It is the intent of the OHS to conduct a comprehensive, fair and impartial evaluation of the Responses received to this competitive procurement. Only those submissions found to be responsive to the RFP requirements will be evaluated and scored.

A team consisting of qualified experts will review the applications to assess the degree of responsiveness, and clarity in their plan to meet the project goals and milestones. The review process will include the following:

- To be considered for review, applications will first be screened for completeness and adherence to eligibility.
- The review panel will assess each application to determine the merits of the proposal. The OHS reserves the right to request that Respondents revise or otherwise modify their proposals and budget based on OHS recommendations.
- OHS may elect to conduct interviews with the finalists prior to awarding the right to negotiate a contract. Any expenses incurred by the Respondent to participate in such interview shall be the responsibility of the Respondent.
- The results of the review of the applications will be used to advise OHS approving official. Final award decisions will be made by the designated approving official. In making these decisions, the approving official will take into consideration: recommendations of the review panel; the readiness of the applicant to complete the scope of work and objectives; and the reasonableness of the estimated cost to the government and anticipated results.
- OHS reserves the right to conduct negotiations with applicants upon receipt of their proposals.

6.2 PROCUREMENT PROCESS

6.2.1 Contract Execution

The contract developed as a result of this RFP is subject to State contracting procedures for executing a contract, which includes approval by the Connecticut Office of the Attorney General. Contracts become executed upon the signature of the Office of the Attorney General and no financial commitments can be made until and unless the contracts have been approved by the Office of the Attorney General. The Office of the Attorney General reviews the contract only after the Program Director and the Contractor have agreed to the provisions.

6.2.2 Acceptance of Content

If acquisition action ensues, the contents of this RFP and the Response of the successful Respondent will form the basis of contractual obligations in the final contract. The resulting contract will be a Personal Service Agreement (PSA) contract between the successful Respondent and the OHS. The OHS is solely responsible for rendering decisions in matters of interpretation on all terms and conditions.

6.2.3 Appeal Process

The Respondent may appeal any aspect of the competitive procurement; however, such appeal must be in writing and must set forth facts or evidence in sufficient and convincing detail for OHS to determine whether – during any aspect of the competitive procurement – there was a failure to comply with the State's statutes, regulations, or standards concerning competitive procurement or the provisions of the Procurement Document. Appeals must be submitted by the Respondent to Demian Fontanella(demian.fontanella@ct.gov), with a copy to the Contract Administrator.

Respondents may submit an Appeal to OHS any time after the submission due date, but not later than thirty (30) days after the OHS notifies Respondents about the outcome of a competitive procurement. The e-mail sent date or the postmark date on the notification envelope will be considered "day one" of the thirty (30) days.

Following the review process of the documentation submitted, but not later than thirty (30) days after receipt of any such Appeal, a written decision will be issued and delivered to the Respondent who filed the Appeal and any other interested party. The decision will summarize the OHS's process for the procurement in question; and indicate the Agency Head's finding(s) as to the merits of the Respondent's Appeal.

Any additional information regarding the Debriefing and/or the Appeal processes may be requested from the Official Contact for this RFP.

6.2.4 Contest of Solicitation of Award

Pursuant to Section 4e-36 of the Connecticut General Statutes, "Any Respondent or RESPONDENT on a state contract may contest the solicitation or award of a contract to a subcommittee of the State Contracting Standards Board…" Refer to the State Contracting Standards Board website at www.ct.gov/scsb.

6.2.5 Disposition of Responses- Rights Reserved

Upon determination that its best interests would be served, the OHS shall have the right to the following:

1. **Cancellation:** Cancel this procurement at any time prior to contract award.
2. **Amend procurement:** Amend this procurement at any time prior to contract award.
3. **Refuse to accept:** Refuse to accept, or return accepted Responses that do not comply with procurement requirements.
4. **Incomplete Business Section**: Reject any Response in which the Business Section is incomplete or in which there are significant inconsistencies or inaccuracies. The State reserves the right to reject all Responses.

5. **Prior contract default:** Reject the submission of any Respondent in default of any prior contract or for misrepresentation of material presented.
6. **Received after due date:** Reject any Response that is received after the deadline.
7. **Written clarification:** Require Respondents, at their own expense, to submit written clarification of their Response in a manner or format that OHS may require.
8. **Oral clarification:** Require Respondents, at their own expense, to make oral presentations at a time selected and in a place provided by OHS. Invite Respondents, but not necessarily all, to make an oral presentation to assist OHS in their determination of award. The OHS further reserves the right to limit the number of Respondents invited to make such a presentation. The oral presentation shall only be permitted for clarification purposes and not to allow changes to be made to the submission.
9. **No changes:** Allow no additions or changes to the original Response after the due date specified herein, except as may be authorized by OHS.
10. **Property of the State:** Own all Responses submitted in response to this procurement upon receipt by OHS.
11. **Separate service negotiation:** Negotiate separately any service in any manner necessary to serve the best interest of the State.
12. **All or any portion:** Contract for all or any portion of the scope of work or tasks contained within this RFP, with one or more Respondents.
13. **Most advantageous Response:** Consider cost and all factors in determining the most advantageous Response for OHS when awarding the right to negotiate a contract.
14. **Technical defects:** Waive technical defects, irregularities and omissions, if in its judgment the best interests of OHS will be served.
15. **Privileged and confidential communication:** Share the contents of any Response with any of its designees for purposes of evaluating the Response to make an award. The contents of all meetings, including the first, second and any subsequent meetings and all communications in the course of negotiating and arriving at the terms of the Contract shall be privileged and confidential.
16. **Best and Final Offers:** Seek Best and Final Offers (BFO) on price from Respondents upon review of the scored criteria. In addition, OHS reserves the right to set parameters on any BFOs it receives.
17. **Unacceptable Responses:** Reopen the bidding process if the SIM determines that all Responses are unacceptable.

6.2.6 Qualification Preparation Expenses

OHS assumes no liability for payment of expenses incurred by Respondents in preparing and submitting Responses to this procurement.

6.2.7 Response Date and Time

To be considered for selection a Response must be received by OHS by the date and time stated in the Executive Summary of this RFP. Respondents should not interpret or otherwise construe receipt of a Response after the closing date and time as acceptance of the Response, since the actual receipt of the

document is a clerical function. OHS suggests the Respondent e-mail the proposal with receipt confirmation. Respondents must address all RFP communications to OHS.

6.2.8 Assurances and Acceptances

1. **Independent Price Determination**: By submission of a Response and through assurances given in its Transmittal Letter, the Respondent certifies that in connection with this procurement the following requirements have been met.

    a. Costs: The costs proposed have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such process with any other organization or with any competitor;

    b. Disclosure: Unless otherwise required by law, the costs quoted have not been knowingly disclosed by the Respondent on a prior basis directly or indirectly to any other organization or to any competitor;

    c. Competition: No attempt has been made or will be made by the Respondent to induce any other person or firm to submit or not to submit a Response for the purpose of restricting competition;

    d. Prior Knowledge: The Respondent had no prior knowledge of the RFP contents prior to actual receipt of the RFP and had no part in the RFP development; and

    e. Offer of Gratuities: The Respondent certifies that no elected or appointed official or employee of the State of Connecticut has or will benefit financially or materially from this procurement. Any contract arising from this procurement may be terminated by the State if it is determined that gratuities of any kind were either offered to or received by any of the aforementioned officials or employees from the contractor, the contractor's agent or the contractor's employee(s).

2. **Valid and Binding Offer:** Each Response represents a valid and binding offer to OHS to provide services in accordance with the terms and provisions described in this RFP and any amendments or attachments hereto.

3. **Press Releases**: The Respondent agrees to obtain prior written consent and approval from the OHS for press releases that relate in any manner to this RFP or any resulting contract.

4. **Restrictions on Communications with OHS Staff:** The Respondent agrees that from the date of release of this RFP until OHS makes an award that it shall not communicate with OHS staff on matters relating to this RFP except as provided herein.. Any other communication concerning this RFP with any of the OHS's staff may, at the discretion of OHS, result in the disqualification of that Respondent's Submission.

5. **Acceptance of the OHS's Rights Reserved:** The Respondent accepts the rights reserved by OHS.

6. **Experience**: The Respondent has sufficient project design and management experience to perform the tasks identified in this RFP. The Respondent also acknowledges and allows OHS to examine the Respondent's claim with regard to experience by allowing OHS to review the related contracts or to interview contracting entities for the related contracts.

6.2.9 Incurring Costs

OHS is not liable for any cost incurred by the Respondent prior to the effective date of a contract.

6.2.10 Statutory and Regulatory Compliance

By submitting a proposal in response to this RFP, the proposer implicitly agrees to comply with all applicable State and federal laws and regulations, including, but not limited to, the following:

1. Freedom of Information, C.G.S. § 1-210(b). This Contract is subject to C.G.S. § 1-1210(b). The Freedom of Information Act (FOIA) requires the disclosure of documents in the possession of the State upon request of any citizen, unless the content of the document falls within certain categories of exemption, as defined by C.G.S. § 1-1210(b). The proposer shall indicate if it believes that certain documents or a portion(s) of documents, as required by this RFP is confidential, proprietary or trade secret by clearly marking such in its response to this RFP. The State will make an independent determination as to the validity under FOIA of the proposer's marking of documents or portions of documents it believes should be exempt from disclosure. While a proposer may claim an exemption to the State's FOIA, the final administrative authority to release or exempt any or all material so identified rests with the State. The State has no obligation to initiate, prosecute, or defend any legal proceeding or to seek a protective order or other similar relief to prevent disclosure of any information pursuant to a FOIA request. The proposer has the burden of establishing the availability of any FOIA exemption in any proceeding where it is an issue. In no event shall the State or any of its employees have any liability for disclosure of documents or information in the possession of the State and which the State or its employees believe(s) to be required pursuant to the FOIA or other requirements of law.

2. Contract Compliance, C.G.S. § 4a-60 and Regulations of CT State Agencies § 46a-68j-21 thru 43, inclusive. CT statute and regulations impose certain obligations on State agencies (as well as contractors and subcontractors doing business with the State) to insure that State agencies do not enter into contracts with organizations or businesses that discriminate against protected class persons.

3. Consulting Agreements, C.G.S. § 4a-81. Proposals for State contracts with a value of $50,000 or more in a calendar or fiscal year, excluding leases and licensing agreements of any value, shall include a consulting agreement affidavit attesting to whether any consulting agreement has been entered into in connection with the proposal. As used herein "consulting agreement" means any written or oral agreement to retain the services, for a fee, of a consultant for the purposes of (a) Providing counsel to a contractor, vendor, consultant or other entity seeking to conduct, or conducting, business with the State, (b) Contacting, whether in writing or orally, any executive, judicial, or administrative office of the State, including any department, institution, bureau, board, commission, authority, official or employee for the purpose of solicitation, dispute resolution, introduction, requests for information or (c) Any other similar activity related to such contract. Consulting agreement does not include any agreements entered into with a consultant who is registered under the provisions of C.G.S. Chapter 10 as of the date such affidavit is submitted in accordance with the provisions of C.G.S. § 4a-81. The Consulting Agreement Affidavit (OPM Ethics Form 5) is available on OPM's website at http://www.ct.gov/opm/fin/ethics_forms

4. Gift and Campaign Contributions, C.G.S. §§ 4-250 and 4-252(c); Governor M. Jodi Rell's Executive Orders No. 1, Para. 8 and No. 7C, Para. 10; C.G.S. § 9-612(g)(2). If a proposer is awarded an opportunity to negotiate a contract with an anticipated value of $50,000 or more in a calendar or

fiscal year, the proposer must fully disclose any gifts or lawful contributions made to campaigns of candidates for statewide public office or the General Assembly. Municipalities and CT State agencies are exempt from this requirement. The gift and campaign contributions certification (OPM Ethics Form 1) is available on OPM's website at http://www.ct.gov/opm/fin/ethics_forms

5. Nondiscrimination Certification, C.G.S. §§ 4a-60(a)(1) and 4a-60a(a)(1). If a proposer is awarded an opportunity to negotiate a contract, the proposer must provide the Department with written representation or documentation that certifies the proposer complies with the State's nondiscrimination agreements and warranties. A nondiscrimination certification is required for all State contracts–regardless of type, term, cost, or value. Municipalities and CT State agencies are exempt from this requirement. The nondiscrimination certification forms are available on OPM's website at http://www.ct.gov/opm/fin/nondiscrim_forms.

6.2.11 Key Personnel

OHS reserves the right to approve any additions, deletions, or changes in key personnel, with the exception of key personnel who have terminated employment. The department also reserves the right to approve replacements for key personnel who have terminated employment. OHS further reserves the right to require the removal and replacement of any of the proposer's key personnel who do not perform adequately, regardless of whether they were previously approved by OHS.

6.2.12 Other

Bidding on and/or being awarded this contract shall not automatically preclude the Respondent from bidding on any future contracts related to OHS. Continued funding is contingent upon the ongoing availability of funds, satisfactory program performance, and demonstrated need for these services.

A. DEFINITIONS AND ACRONYMS

DEFINITIONS

1. **All Payer Claims Database (APCD)** – refers to the state's claims data provided by the health insurance carriers.
2. **"Core Measures**" - a measure set assessing primary care, specialty, and hospital provider performance and a common provider scorecard format for all payers and across the health ecosystem.
3. "**Data Use Strategy**" - refers to OHS' plan to purposefully leverage state and other publicly available data to achieve the objectives for Executive Order No. 5.
4. "**EXECUTIVE ORDER NO. 5" -** signed by Governor Lamont on 1/1/2020, the order directs the Office of Health Strategy (OHS) to develop annual healthcare cost growth benchmarks for calendar years (CY) 2021-2025, and to implement several additional, related initiative, including a primary care target and quality benchmarks.
5. **"Healthcare cost growth benchmark or (CGBM)** - a targeted annual per capita maximum rate of spending growth that payers, providers, and the State are expected to adhere to.
6. "**Microsoft Azure"** - commonly referred to as **Azure**, is a cloud computing service created by Microsoft for building, testing, deploying, and managing applications and services through Microsoft-managed data centers.
7. "**Office of Health Strategy (OHS)"-** established by the Connecticut General Assembly in 2018, the mission of OHS is to implement comprehensive, data driven strategies that promote equal access to high quality health care, control costs and ensure better health for the people of Connecticut.
8. **"Primary Care Spending Target "-** establishes a goal for increasing statewide primary care spending as a percentage of total health care expenditures.
9. "**Quality Measures"** - set that may include core measures and population health measures that would be reported for the purposes of EO5 and applied similarly to the cost growth benchmark and primary care target, at the State, market, payer, and provider organization levels.

ACRONYMS

APCD All Payer Claims Database

CGBM Cost Growth Benchmark

CHAI Connecticut Healthcare Affordability Index

EO5 Executive Order No. 5

OHS Office of Health Strategy

RFP Request for Proposals

ATTACHMENT A: PROPOSAL FACE SHEET

OFFICE OF HEALTH STRATEGY
REQUEST FOR PROPOSALS (RFP)
PROJECT NAME
PROPOSAL FACE SHEET

1	**RESPONDING AGENCY** (Legal name and address of organization as filed with the Secretary of State): Legal Name: _____ Street Address: _____ Town/City/State/Zip: _____ FEIN: _____
2	**DIRECTOR/CEO** Name: _____ Title: _____ Telephone: _____ FAX: _____ Email: _____
3	**CONTACT PERSON** Name: _____ Title: _____ Telephone: _____ FAX: _____ Email: _____

ATTACHMENT B: PROCUREMENT AND CONTRACTUAL AGREEMENTS SIGNATORY ACCEPTANCE

Statement of Acceptance

The terms and conditions contained in this Request for Proposals constitute a basis for this procurement. These terms and conditions, as well as others so labeled elsewhere in this document are mandatory for the resultant contract. The Office of Health Strategy is solely responsible for rendering decisions in matters of interpretation on all terms and conditions.

On behalf of_____

I, _____agree to accept the Mandatory Terms and Conditions and all other terms and conditions as set forth in the XXX Request for Proposals.

_____

Signature

_____ _____

Title Date

ATTACHMENT C: BUDGET NARRATIVE GUIDANCE

BUDGET NARRATIVE

The Respondent must provide a budget narrative according to the instructions provided here. Costs must be reasonable and consistent with the proposed scope.

The resultant Contract shall include a maximum cost for the contract period (broken down by Year) for the proposed services. Payment shall be based on actual costs incurred not to exceed the Contract maximum for each budget category, and for the Contract overall.

This guidance is offered for the preparation of a budget request. Following this guidance will facilitate the review and approval of a requested budget by ensuring that the required or needed information is provided. In the budget request, awardees should distinguish between activities that will be funded under this agreement and activities funded with other sources.

The Respondent may wish to request funding for personnel from their organization for the activities under this RFP. The Respondent may, alternatively, decide to request the funding for consulting services. If this is the case, these costs can be inserted as a subcontractor costs under C. Consultant Costs.

Please provide a Budget Summary table, as well as justification and cost tables for each of the requested budget categories A-G.

SUMMARY TABLE TEMPLATE (INCLUDE FOR YEARS 1 and 2)

Budget Category	*Total*
A. Personnel	
B. Fringe	
C. Consultant Costs	
D. Supplies	
E. Travel	
F. Other	
G. Total Direct Costs	
H. Indirect Costs	
I. ***Total (F + G)***	

Please include narrative justification as follows:

A. Salaries and Wages

For each requested position, provide the following information: name of staff member occupying the position, if available; annual salary; percentage of time budgeted for this program; total months of salary budgeted; and total salary requested. Also, provide a justification and describe the scope of responsibility for each position, relating it to the accomplishment of program objectives.

Position Title and Name	*Annual*	*Time*	*Months*	*Amount*
Project Coordinator Susan Taylor	*$45,000*	*100%*	*12 months*	*$45,000*
Finance Administrator John Johnson	*$28,500*	*50%*	*12 months*	*$14,250*
Outreach Supervisor (Vacant)*	*$27,000*	*100%*	*12 months*	*$27,000*

Sample Justification

The format may vary, but the description of responsibilities should be directly related to specific program objectives.

Job Description: Project Coordinator - (Name)

This position directs the overall operation of the project; responsible for overseeing the implementation of project activities; coordination with other agencies; development of materials, provisions of in service and training; conducting meetings; designs and directs the gathering, tabulating and interpreting of required data; responsible for overall program evaluation and for staff performance evaluation; and is the responsible authority for ensuring necessary reports/documentation are submitted to HHS. This position relates to all program objectives.

B. Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed. This can be done for all FTE in one table instead of itemizing per employee.

Sample

Example: Project Coordinator — Salary $45,000

Retirement 5% of $45,000	*=*	*$2,250*
FICA 7.65% of $45,000	*=*	*3,443*
Insurance	*=*	*2,000*
Workers' Compensation	*=*	_____
	Total:	

C. Consultant Costs

This category is appropriate when hiring an individual to give professional advice or services for a fee but not as an employee of the awardee organization. Hiring a consultant requires submission of the following information:

1. Name of Consultant;
2. Organizational Affiliation (if applicable);
3. Nature of Services to be Rendered;
4. Relevance of Service to the Project;
5. The Number of Days of Consultation (basis for fee); and
6. The Expected Rate of Compensation (travel, per diem, other related expenses)—list a subtotal for each consultant in this category.

If the above information is unknown for any consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. In the body of the budget request, a summary should be provided of the proposed consultants and amounts for each.

D. Supplies

Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. If appropriate, General Office Supplies may be shown by an estimated amount per month times the number of months in the budget category.

Sample Budget

Supplies

General office supplies (pens, pencils, paper, etc.)

12 months x $240/year x 10 staff	=	*$2,400*
Educational Pamphlets (3,000 copies @) $1 each)	=	*$3,000*
Educational Videos (10 copies @ $150 each)	=	*$1,500*
Word Processing Software (@ $400—specify type)	=	*$ 400*

Sample Justification

General office supplies will be used by staff members to carry out daily activities of the program. The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. Word Processing Software will be used to document program activities, process progress reports, etc.

E. Travel

Dollars requested in the travel category should be for **staff travel only**.

Funds cannot be used to pay for contractor travel to a conference (i.e., healthcare benchmark initiative dollars cannot be used to enrich a contractor, dollars can only be used to support healthcare benchmark goals). Travel that is critical and necessary for the successful execution of healthcare benchmark initiative activities will be approved. A robust justification related to the execution of specific healthcare benchmark initiative activities will be needed.

Provide the following specific information when submitting a line item budget for travel:

- Individual Traveling
- Number of trips * Number of Miles * GSA Approved Mileage Rate **OR** Approximate Number of miles per month * GSA Approved Rate (If the mileage is intended for everyday travel to fulfill the requirements of a job, for example, a Community Health Worker)
- Event Costs (i.e. meetings or conferences registration)
- Airfare Costs, detailed by individual flight
- Lodging Costs (must be within federally approved rate), broken down by room cost, tax, and fees
- Per Diem Meal Costs, broken down by Meal Costs, gratuity and tax
- Parking Costs per day or hour
- Car Rental Costs broken down by daily rental rate, taxes, and fees

Travel for Contractors: Travel incurred through a contract should be shown in the contractual category. Generally, this type of travel is approved for speakers and/or subject matter experts, not general stakeholder travel.

Travel for other participants, advisory committees, review panel, etc. should be itemized in the same way specified below and placed in the **"Other".**

In-State Travel—Provide a narrative justification describing the travel staff members will perform. List where travel will be undertaken, number of trips planned, who will be making the trip, and approximate dates. If mileage is to be paid, provide the number of miles and the cost per mile. The mileage rate cannot exceed the rate set by the General Services Administration (GSA). If travel is by air, provide the estimated cost of airfare. If per diem/lodging is to be paid, indicate the number of days and amount of daily per diem as well as the number of nights and estimated cost of lodging. Costs for per diem/lodging cannot exceed the rates set by GSA. Include the cost of ground transportation when applicable. Please refer to the GSA website by using the following link http://www.gsa.gov/portal/content/104877.

Out-of-State Travel: Provide a narrative justification describing the same information requested above. Include HHS meetings, conferences, and workshops, if required by HHS. Itemize out-of-state travel in the format described above.

Sample Travel

1 trip x 2 people x 500 miles r/t x .27/mile	=	*$270*
2 days per diem x $37/day x 2 people	=	*$148*
1 nights lodging x $67/night x 2 people	=	*$134*
25 trips x 1 person x 300 miles avg. x	=	*$2,025*
Total	=	*$2,577*

Sample Justification

The Project Coordinator and the Outreach Supervisor will travel to (location) to attend an eligibility conference. The Project Coordinator will make an estimated 25 trips to local outreach sites to monitor program implementation.

F. Other

This category contains items not included in the previous budget categories. Individually list each item requested and provide appropriate justification related to the program objectives.

Sample Justification

Some items are self-explanatory (telephone, postage, rent) unless the unit rate or total amount requested is excessive. If the items are not self-explanatory and/or the cost is excessive, include additional justification. For printing costs, identify the types and number of copies of documents to be printed (e.g., procedure manuals, annual reports, materials for media campaign).

G. Total Direct Costs $_____

Show total direct costs by listing totals of each category.

WITHHOLD

OHS shall withhold a percentage of the total contract value to be paid to the Contractor that shall only be paid to the Contractor upon the Contractor's completion and submission of all deliverables to OHS and OHS's acceptance of the same. The amount of the withhold shall be 10% of the total contract value. The contingencies for payment of the withhold shall be agreed to during contract negotiations. In the Budget Narrative, the Respondent shall acknowledge and agree to a withhold of 10% of the total contract value and to negotiate, in good faith, the terms of the contract including but not limited to the contingencies for release of the withhold.

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[i] It is straightforward to attribute spending an individual provider using billing or rendering national provider identifier (NPIs). However, many states do not have provider directories in place that map provider NPIs to specific practice sites and/or facilities. Creating and maintaining a provider directory requires significant state commitment and effort.

[ii] CMS. (2017, November 30). Crosswalk Medicare Provider/Supplier to Healthcare Provider Taxonomy. Retrieved February 24, 2021, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf.

[iii] Ibid.

[iv] Frieder, M., Schneider, M., Nam, D., & Stengel, K. (2020, February 13). CMS Proposes Allowing Part D Plans to Implement a New Preferred Specialty Tier. Retrieved February 24, 2021, from https://avalere.com/insights/cms-proposes-allowing-part-d-plans-to-implement-a-new-preferred-specialty-tier#:~:text=Due to a proposed change,2020 to $780 in 2021.

STATE OF CONNECTICUT
OFFICE OF HEALTH STRATEGY

REQUEST FOR PROPOSAL (RFP)
FOR
DATA ANALYTIC SERVICES FOR COST GROWTH BENCHMARK AND PRIMARY CARE TARGET INITIATIVE AND OHS ANALYTIC NEEDS

SECOND Addendum

RELEASE DATE – June 25, 2021

The Office of Health Strategy's official responses to questions submitted as of 5:00 PM, June 21, 2021

I. Users/Analysts

1. **Question**: How many internal analytics users will be using the system as viewers?

   Answer: Six to eight.

2. **Question**: From Page 11, 3.1 Advanced Analytics with Visualization "Provide knowledge transfer to OHS analysts for continued data analytics support for the Initiative"
   How many OHS analysts will need to be provided knowledge transfer for continued data analytics support? And, in general, which software tools are they trained in and comfortable using?

   Answer: Two to three. SQL, Python, Tableau.

3. **Question** Can the respondent assume that OHS staff currently works within Azure cloud-based solution, or will this be a new application for the staff?

   Answer: This would be a new application for staff.

4. **Question:** After commencement of training of OHS personnel, will the vendor be expected to provide ongoing production support?

   Answer: The vendor will be expected to provide support during the 5 year contract.

II. Data Analytics/Reporting

1. **Question**: Where is the historical data (2012-2020) currently stored? And in what format (SQL, CSV, Other)?

   Answer: Historical data is in AWS and will be made available but could be also in SQL Server.

2. **Question**: Are there existing web pages that will be used for showcasing the public-facing reports? Or will a new public-facing website be developed for this solution?

   Answer: Yes, and OHS will link or do the integration.

3. **Question**: Does the solution require migrating historical data (2012-2020) into the Azure environment?

   Answer: Yes

4. **Question**: For the additional mentioned data sources (hospital inpatient and outpatient surgery and financial data and other publicly available healthcare and/or demographic data such as from US Census, Centers for Medicare and Medicaid Services Chronic Conditions Data Warehouse, National Committee for Quality Assurance, US Health and Human Services measurement metrics and data), does OHS have current license or access to that data, or host it in a way that would be accessible to an Azure cloud solution?

   Answer: OHS owns the hospital inpatient, outpatient, and financial data and houses them as SQL databases. Apart from data available on the US. Census Bureau and CT Department of Public Health websites, OHS does not have a current license, access to or host in a way that will be accessible to an Azure cloud solution. Proposals and feasibility are part of this request.

5. **Question**: Is there a requirement to integrate with an existing Security Operations Center (SOC) and Security Information and Event Management (SIEM) system? Or is the requirement that the vendor will provide those services as part of the RFP?

   Answer: No, the State will provide that.

6. **Question**: Are there currently any dashboards/reports that would need to be maintained or recreated, and if so, what frequency is the data required to be updated/refreshed?

   Answer: There are some current dashboards/reports to be maintained or recreated. There might be occasional data refresh.

7. **Question**: Are there preferred BI tools for generating report and build dashboard? (e.g PowerBI, Tableau ...)?

   Answer: Tableau is an acceptable option as OHS has the desktop licenses already.

8. **Question**: Is there a known list of standard reports do we have to build?

   Answer: The list of standard reports are specified in the Scope of Work.

9. **Question**: Does this infer the use of AI components for this requirement?

   Answer: There is no inference; solution proposals are up to the bidder.

10. **Question**: Could you provide more detail on Statistical Modeling? Is it related to AI component? If yes, will we have to build an environment so that we can build/run AI models on it?"

    Answer: There is no AI component. The solution to build/run AI models are up to bidder.

11. **Question** What are current tool sets, tech stack for analytic framework & visualization for "CURRENT WORK"?

    Answer: Tableau, SQL, Python

12. **Question:** Are there any data tools / framework that run on-premise?

    Answer: Tableau

13. **Question:** Are there any data warehouse, data pipelines available so our data analyst can use them to analyze the data or we should build from scratch?

    Answer: Data is stored in AWS and, if necessary, also SQL Server.

14. **Question:** What is the data growth rate?

    Answer: An average of 10% per year.

15. **Question:** As mentioned in the RFP, the ""OHS' current data analytics vendor has completed and presented the results of the initial analyses listed in the analytic framework"". Could you please share more about the scope/output of the initial analyses?

    Answer: The scope of the initial analyses is described in pages 10-11 of the RFP document**.**

16. **Question:** Could we reuse/maintain the code/framework of ""initial analyses""? If yes, could you please share with us the technology stack which is being used?"

    Answer: The code/framework used for the initial analyses was SAS based. OHS is looking for a solution that enables automation.

17. **Question**: Regarding to "initial analyses", what level does the Analyses framework cover?

    Answer: The "initial analyses" were at the state, market, payer, and service category level.

18. **Question:** As mentioned, databases listed: "OHS All-Payer Claims Database (APCD), Hospital Discharge Database, Outpatient Surgical Center Database, Hospital Reporting System", Are they hosted on premise or on cloud? And which database solution is being used?

    Answer: The OHS APCD is hosted in AWS and the remaining are hosted on virtual servers with the State's system. Data are analyzed with SPSS, Tableau, Excel, and SQL.

19. **Question**: As mentioned, the Analytic Framework covered the data analyst in APCD, is there other data mentioned, are there other data sources to consider?

    Answer: The additional data sources are on described on pages 11-12 of the RFP document.

20. **Question**: **RFP Section 3.1 ("ADVANCED ANALYTICS WITH VISUALIZATIONS"), Page, 11:** Besides the request to take in hospital financial data, does OHS have any additional information on the sources and types of non-claims financial data the vendor will need to take in and analyze?

    Answer: Hospital financial data is the only source of financial data at this point.

21. **Question: RFP Section 2.2, D ("QUALITY BENCHMARKS"), Page 9:** Does the state have any additional information or a link to the types of measures and quantity of measures you are considering for the OHS Quality Benchmarks? Can you clarify if the State intends to have quality measures created from APCD claims data or if instead you will acquire quality measures (e.g., HEDIS) from the Health Plans?

    Answer: The list of quality benchmarks and likely data sources are available at https://portal.ct.gov/OHS/Pages/Quality-Council/Core-Measure-Set

22. **Question: RFP Section 1 ("Executive Summary"), Page 5:** As relating to **"**OHS All-Payer Claims Database (APCD), Hospital Discharge Database, Outpatient Surgical Center Database, Hospital Reporting System, and other publicly available data sets" **-** can the state provide any additional detail on data sources you know will be used for "other publicly available data sets?"

    Answer: Examples of sources of publicly available healthcare and/or demographic data are listed on page 12 section 3.2 of RFP document.

23. **Question : RFP Section A ("Statement of Objectives"), Page 1:** Is it assumed that the Data Analytics vendor will not create the CT Healthcare Affordability Index (CHAI), but instead is only involved in "statistical modelling of healthcare initiatives from the CHAI? What role, if any, does the Data Analytics vendor play in creating the CHAI index and data?

    Answer: The index is already created, but the vendor may be involved in statistical modeling.

24. **Question: RFP Section A ("Statement of Objectives"), Page, 1:** From the CHAI index links, the 130 page 2019 self-sufficiency reporting includes information that is not found in claims data. Are there specific areas in that report that the proposed vendor will be required to acquire or generate data to populate? (https://portal.ct.gov/-/media/OHS/CT-Healthcare-Affordability-Index/Self-Sufficiency-Standard/CT2019_SSS_Web_20191014.pdf)

    Answer: All reports will be created using data OHS has already collected.

25. **Question: RFP Section 3 ("Required Service Components and Scope of Work"), Page, 10:** From the RFP Section 3 "Required Service Components and Scope of Work", the "Analytics Framework" indicates a series of "Domains", "Initial Work, 2020" and "Extensions". The initial work appears to be Commercial, Medical Claims, and the Extensions add Medicare, Medicaid, Pharmacy, and Dental. Does OHS require the vendor to replicate the methods used by the current vendor? To what degree, if any, can the Data Analytics vendor vary from the methods used by the current vendor?

    Answer: OHS will not require the vendor to replicate the methods used by the current vendor.

26. **Question:** Is there an enterprise-wide Master Patient Index with which the APCD, hospital patient, and financial data, and other data must correlate?

    Answer: There is no enterprise-wide Master Patient Index but there is a data dictionary compendium.

27. **Question:** Has the State received ResDAC approval to use CMS data?

    Answer: Yes.

28. **Question:** What is the approved risk scoring methodology for SDoH? Should the vendor propose and get approval for use of a publicly available risk score to perform the value-based modeling required?

    Answer: The vendor may propose and may receive approval to use a publicly available and nationally recognized and/or acceptable risk score to perform any required value-based modeling.

29. **Question:** Please provide a definition for "low-value services" and "market concentration" in the Analytics Framework table on page 11 of the RFP.

    Answer: A “low value service” is one defined as medically unnecessary, providing no health benefits or may be harmful to the patient, and may lead to further unnecessary testing or treatment. “Market concentration” is when a small number of providers, e.g., hospitals or hospital systems, account for a relatively large share of patients in a town, area or region. In both cases, there are nationally recognized/accepted measurement tools.

30. **Question:** Which data source contains the SDoH data and what format will it come in?

    Answer: Combination of data existing in the APCD, Discharge and Outpatient Data, publicly available data from CMS and/or Census Bureau or any other sources.

31. **Question:** Will the state consider a vendor-owned SaaS solution?

    Answer: No, OHS will own the solution.

32. **Question:** Can OHS give further explanation and/or examples of the type of "direct code" that bidder will need to provide?

    Answer: OHS will retain all source code used for analytics and data use.

33. **Question:** Should the vendor include Quality Assurance (QA) testing as in-scope services or will OHS be executing QA testing on deliverables?

    Answer: OHS and the vendor will share QA responsibilities.

34. **Question: RFP Section 3.2 (“Option with Business Solution - Level of Analysis”), Page, 13:** In 3.2 under the Levels of Analysis table on last row, “Provider Entity,” the RFP states “Practice/practice site, facility, clinician and facility specialty type, site of service”. Also in the Analytic Framework the RFP mentions “provider groups”.

    Will CT APCD or OHS be providing rosters or reference data files that can used to link specific professionals to their practice or practice site or provider groups? Does OHS

require the vendor to perform provider attribution, for example, determining a members primary care physician and practice from the claims data?

Answer: The CT APCD contains reference data files, and OHS will provide the methodology for primary provider attribution as well.

III. Cloud Based Solution

1. **Question**: Is there existing infrastructure to leverage or begin with to just focus on Development?

   Answer: Yes, the state has an Azure environment but OHS' primary focus is on development.

2. **Question:** In reference to the 3.2 Business Solution Option, could you clarify if OHS wants Azure hosted in your environment or within the bidding vendor's environment?

   Answer: OHS will utilize the state Azure environment.

3. **Question**: Is any of this data already present in an Azure or other cloud-based solution? Or does it require migration to the new Azure solution?

   Answer: Yes, it will require migration to the new Azure solution.

4. **Question**: From Page 5/ Executive Summary "OHS also requires the contractor experienced in cloud-based architecture to provide an option to develop a Azure cloud-based analytic solution using OHS data, however the advanced health data analytic reporting is the primary deliverable."

   Is the expectation that the solution is hosted within a new or existing OHS Azure tenant? Or are Azure resources to be hosted in Respondent's Azure tenant?

   Answer: The solution should be hosted in the state of Connecticut Azure tenant environment.

5. **Question** Have you built a data warehouse for advanced data analytic? if not, is this step in our scope?

Answer: No, the respondent will have to build a data warehouse for advanced data analytics.

6. **Question:** Please provide an estimate of the size of total data to be hosted?

   Answer: 1 TB at a minimum.

7. **Question**: From Page 13, 3.2 Option with Business Solution "Develop sufficient analytic tools and provide technical training to enable OHS analysts to independently monitor healthcare cost and performance trends across plans, payers, and populations, and to support OHS operations"

   Regarding the Option with Business Solution, how many OHS analysts will need to be provided knowledge transfer to independently monitor healthcare cost and performance trends? And, in general, do they have skills and experience in using Azure cloud-based analytics tools?

   Answer: Two to three OHS analysts for the technical part of updating the information in the tool and six to eight OHS analysts to view and run analyses will need to be provided knowledge transfer to independently monitor healthcare cost and performance trends. The staff will be new to using Azure cloud-based solutions.

8. **Question**: Do you want to process data as batch processing or stream processing?

   Answer: Batch processing.

9. **Question**: What kind of data formats do you want to process? structured data, semi-structured data or un-structured data?

   Answer: Structured data.

10. **Question**: When moving data into the cloud what data should be considered for encryption? (i.e. other than PII, HIPPA, etc.)

    Answer: All data should be encrypted at rest and in transit.

11. **Question**: Regarding merging the data into a single unified data architecture, do you have a tech stack defined as a structure to follow or it will be up to vendor's decision?

    Answer: OHS expects a tech stack defined as a structure with possible adjustments or changes as necessary.

VI. Procurement Process/Bid Submission

1. **Question**: Page 23, VI. Show Us Your Solution. "The agency will either invite selected applicants to meet in Hartford, CT, or to have a virtual demonstration, to demonstrate a prototype that will help to visualize the proposed solution."

   When will demos of proposed solutions be scheduled?

   Answer: The deadline for submissions is July 12, and OHS anticipates having demos in mid-July through the beginning of August.

2. **Question**: Are you planning a call with vendors to provide the background and other details?

   Answer: Currently, OHS is not planning a call with vendors due to the tight timeframe.

3. **Question**: Taking into consideration the extended proposal due date, does OHS anticipate a different contract start date and key outputs and timeline?

   Answer: No, at this time OHS does not anticipate an extended proposal due date or a change to key outputs and timelines.

4. **Question**: Would it be possible to increase the page limits for the project narrative and the qualifications and project management sections?

   Answer: Yes, you can use up to 5 pages for the project narrative and up to 5 pages for the qualifications and project management sections.

5. **Question**: Would it be possible to exclude the space allocated to the workplan from the page limit for the qualifications and project management section?

Answer: No, OHS is allowing 5 pages for the qualifications and project management sections. The resumes do not count towards the page count.

6. **Question**: Is it possible to include examples of work product? Can those pages be excluded from the page limit?

   Answer: Yes, you can provide 3 pages of examples of work product outside of the page limit.

7. **Question**: Will OHS consider making an award to more than one vendor? For example, if OHS likes the overall proposal by one vendor, but likes the unique analytics provided by another, would OHS consider making awards to both?

   Answer: Currently, OHS is considering an award to a single vendor. This does not preclude a vendor from subcontracting some activities.

8. **Question**: Does OHS have specific analytics that it wants, such as HEDIS, CAHPS, Press Ganey, etc.?

   Answer: Details of the analytics requirements are included in the RFP. Quality benchmarks as determined by OHS' Quality Council can be found here: https://portal.ct.gov/OHS/Pages/Quality-Council/Meeting-Agendas/June-17-2021

9. **Question**: Page 22, Section 5.2 > V. Qualifications and Project Management. "(2 pages, single spaced, Resumes do not count towards the page limit)"

   Does the 2-page limit apply to all sections, except resumes, combined (1. Qualifications and Experience, 2. References, 3. Organizational and Project Structure, 4. Project Management, and 6. Project Plan and Timeline = 2 pages total)? Or, does the 2-page limit apply to each subsection (1. Qualifications and Experience, 2. References, 3. Organizational and Project Structure, 4. Project Management, and 6. Project Plan and Timeline = 2 pages each, or 10 pages total)?

   If the former, can the page limit please be extended? The questions themselves take up more than one page in 12-point font, and we do not believe we can provide adequate answers to all of the questions with 1-2 sentences for each response.

   Answer: The page limit has been extended to 5 pages combined and not to each subsection.

10. **Question** Attachment B Procurement and Contractual Agreements Signatory Acceptance. "These terms and conditions, as well as others so labeled elsewhere in this document are mandatory for the resultant contract."

    Can respondents request redlines or exceptions to RFP terms and conditions, or would requests for exceptions to terms disqualify the respondent.

    Answer: Respondents must accept all mandatory terms and conditions outlined in the RFP. If the respondent does not accept these terms, the respondent will not have met minimum qualifications for the solicitation.

11. **Question**: Attachment C > Budget Narrative. “Salaries and Wages and B. Fringe Benefits”

    We are unable to submit the requested salary and wage and fringe benefit information in a public bid process due to confidentiality agreements with the employees we are putting forth to work on the project. We can include the cost to OHS of each role in the proposed project team. Will this be sufficient for parts A and B of the Budget Narrative, or does inability to submit this information disqualify the respondent?

    Answer: A list of the staff hourly rate and estimate of materials is sufficient.

12. **Question**: Is this RFP follow on work from an initial project/engagement?

    Answer: This data analyses are to continue and expand the data analyses from a prior contractor. The option for business solution is not follow up work.

13. **Question**: Can you provide some background as to the consultants referenced and their role in this work?

    Answer: The consultants are Bailit Health and they have sub-contracted with an analytical firm.

14. **Question**: Given the nature of this work, would a firm be considered at a disadvantage if not locally headquartered in CT?

    Answer: No, a firm does not have to be located in Connecticut.

15. **Question**: 4.4 “Termination of Award” Assuming satisfactory performance, what is the review timeline and/or notification period if for any reason (other than lack of satisfactory work) the award can be terminated?

    Answer: The resulting contract may be terminated by OHS upon the provision of sixty days prior written notice delivered by certified mail.

16. **Question**: Section 5.2 VI “Show us your solution”. Is it presumed that qualified candidates will be required to demonstrate a prototype/model of the solution within the two week time frame of submission deadline June 28, and anticipated notice of aware July 14, 2021? The date is not spelled out on page 5 of the timeline.

    Answer: The deadline for submissions is July 12, and OHS anticipates having demos in mid-July through the beginning of August.

17. **Question:** Is it a fixed price model or time material project?

    Answer: This is a time and material project.

18. **Question:** What are the expectations / content to be show on the demo?

    Answer: The priority is the analytic component showing trend data as described on page 10-11, 15- 16. Accessing the data in an Azure cloud-based solution would be secondary.

19. **Question**: If there is any additional information you can share around budget or what type of contract, that would be helpful in putting together a competitive proposal.

    Answer: OHS is not disclosing the budget per the State’s procurement standards. The contract is hourly, based on time, expenses, and materials.

20. **Question:** May the font size for table, header/footer, and RFP reference text be smaller than 12 points; for example, 10 points?

    Answer: The font size for table, header/footer, and RFP reference text can be 10 points.

21. **Question:** There is no Attachment D in the RFP document. Will the attachment be forthcoming or should vendors refer only to Attachment C for guidance?

    Answer: There is no Attachment D – that was an error. Please refer to Attachment C for guidance.

22. **Question:** Is the Project Plan and Timeline included in the 2-page limit for the "Qualifications and Project Management" section or may it be submitted as an Appendix.

    Answer: The page count has been increased to 5 pages.

23. **Question:** Has funding already been allocated for this project?

    Answer: Funding is available for this project.

24. **Question:** Is there an identified target budget?

    Answer: OHS are not disclosing a target budget per the State's procurement standards.

25. **Question:** Can the deliverables documentation produced by the current data analytic vendor during the initial analysis phase be provided to bidders?

    Answer: There is an example of work in the RFP on pages 11, 15, and 16.

26. **Question:** Typically, government agencies require fixed price deliverables-based contracts, but the "Cost Proposal" section VII asks for fully burdened hourly rates. Does this imply an hourly Time & Expenses engagement?

    Answer: Yes, this is a time and expenses contract.

27. **Question:** Are there any data security policies or information technology security policies to which the bidder's solution must adhere? If so, can you please provide reference to those policies?

    Answer: The respondent must adhere to HIPAA guidelines.

STATE OF CONNECTICUT
OFFICE OF HEALTH STRATEGY

REQUEST FOR PROPOSAL (RFP)
FOR
DATA ANALYTIC SERVICES FOR COST GROWTH BENCHMARK AND PRIMARY CARE TARGET INITIATIVE AND OHS ANALYTIC NEEDS

THIRD Addendum

RELEASE DATE – June 30, 2021

The Office of Health Strategy's official responses to questions submitted as of 5:00 PM, June 28, 2021

1. **Question:** Does OHS have a strict preference for Azure cloud or would they be willing to consider other cloud vendors such as AWS or Google cloud?

   Answer: OHS will utilize the state Azure environment but OHS' primary focus is on development.

2. **Question:** Can OHS provide more detail on the level of effort sought, such as estimates of numbers of FTE staff dedicated to the project, to ensure that proposed responses align with available resources? How many users do you envision for the web-based reports and dashboards?

   Answer: The analytic vendor for OHS has five to seven staff working on an hourly basis when analyses are requested. For OHS' in-house analyses, there are two to three staff dedicated to the project and six to eight internal analytics users for web-based reports and dashboards.

3. **Question:** If possible, please provide additional specifications for the healthcare services pricing tool? How does this relate to the pricing tool that is already available in CT? https://healthscorect.com/

   Answer: This is to upgrade the pricing tool at https://healthscorect.com/, show potential pricing and out of pocket payment ranges based on payer: for bundled or episodes of services; for additional services not just the top 25 services; and for more providers than currently listed. The upgrade should also allow consumers to find service availability by, for example, town and/or zip codes or provider address, depending on state and federal cell suppression policies.

4. **Question:** Can OHS provide more details of its vision for potential web-based access to the reports or measures that the public could access?

Answer: Reports may include dashboards depicting healthcare utilization, spending, cost, payments, quality, and access trends within Connecticut: by region, county, or towns in comparison with statewide or New England; and/or national trends. Reports/dashboards should also allow for related data downloads, if feasible, and in line with state and federal requirements such as the Health Insurance Portability and Accountability Act (HIPAA).

5. **Question:** Does OHS plan to host the cloud-based Azure solution where the contractor will build data visualizations, etc.? Or does OHS expect the contractor to host and operate the environment and regular uploads of refreshed data? (Or some other approach?)

   Answer: OHS would host the cloud-based Azure solution.

6. **Question:** The qualifications and project management section is limited to two pages. Which elements are included/excluded in the page limit? Are the resumes excluded from this limit? Is the project plan excluded from this limit?

   Answer: The page count for this section has been extended to 5 pages. Resumes are excluded from this limit. The project plan is not.

7. **Question:** For the demonstration (show us your solution), what is OHS looking for -high-level concepts or a minimum viable product? Will OHS be providing data for the respondents to use in the demonstration, or should respondents plan to draw on their own data?

   Answer: For the demonstration, a high-level concept would be preferred, but if the respondent cannot offer that then a minimum viable product is acceptable. Respondents should plan to draw on their own data.

8. **Question: RFP Section 3 ("Required Service Components and Scope of Work - Analytic Framework"), Page, 11:** The RFP mentions "episodes of care" in the Extensions column of the "Analytic Framework" table. As there are commercially available episode groupers that can be applied depending on use case, does OHS want the vendor to include the commercially available episode groupers in our proposal scope and budget?

   Answer: A health status grouper is not included in the project; , the vendor may include commercially available episode grouper options in the proposal scope and budget.

9. **Question: General Question:** The RFP does not specify use of a health status grouper (e.g., CRG, ACG, HCC) on claims data. Does OHS anticipate the use of a specific health status grouper for this project? Should the vendor assume this will already be provided in the data?

   Answer: The vendor may include commercially available episode groupers in the proposal scope and budget.

10. **Question:** What is the rationale for the current target mentioned for calendar year 2025 regarding targeting "increased primary care spending as a percentage of total health care

expenditures to reach a target of 10%"? What is the current percentage? Is similar secondary/specialty care data available for same/similar data analytics and reporting?

Answer: The 10% primary care spending target is part of the Executive Order No. 5. https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-5.pdf

As referenced on page 9 of the RFP, the current percentage of primary care spend we estimate at 4.8%, with a goal to hit 5% spend this year. We do have secondary/specialty care available for similar data analytics and reporting. Currently, our focus is on primary care spend rather than specialty care per the mandate.

11. **Question:** What, if any, national benchmarking data resources, databases, etc. are already in use by OHS in addition to those specifically listed in the RFP?

    Answer: OHS is using the national benchmarking databases listed in the RFP, but that does not preclude OHS from using other sources of data.

12. **Question:** It is clear that benchmarking across US states occurs/exists already. What is the level of desire to benchmark internationally? What is the level of desire to benchmark internally in this solution for comparative performance analysis?

    Answer: OHS is not benchmarking internationally yet, although benchmarking internally is more likely.

13. **Question:** Is it permitted to extend, enhance or alter the quoted framework for Data Use Strategy Analyses if valuable to the project and/or stakeholders?

    Answer: OHS prefers to start with the quoted framework as there are recurring reports that are expected in the deliverables. If the analyses showed a reason to extend or enhance the framework, it would have to be driven by the quoted framework analyses and considered ad hoc.

14. **Question:** Have these data sets been linked and used before in Connecticut? If yes, what additional information can you share regarding the detail, existing structure, and/or access to the existing integrated data?

    Answer: OHS is currently working in-house to link the datasets together.

15. **Question:** OHS has defined the problem they are trying to solve and some of the requirements. Is it anticipated that OHS and the selected applicant will conduct specifications scoping and planning, or are specifications, features, etc. already decided and will be provided to the awarded applicant as a prepared requirements document? If the latter, can any details or drafts be shared in advance?

    Answer: Specifications of the analysis are provided on page 13 of the RFP under "Standard Reports." OHS has not developed a requirements document other than the analyses listed in the RFP.

16. **Question:** Could you provide examples of "Experience managing ad-hoc reporting that goes beyond the regularly scheduled standard reports."

    Answer: There may be ad hoc reports arising from the standard analyses and reports, where OHS would like a "deeper dive", or ones that fall outside the benchmark initiative but still need reporting (e.g., COVID claims monitoring or in- and out-of-network costs). Some reports may be at the request of the governor, legislature, or other governing bodies.

17. **Question:** In "Key Outputs and Timeline" one deliverable is to "Present findings of analyses to OHS staff, consultants, stakeholders, advisory bodies, and the public as OHS requests." Is it expected that the awarded applicant will provide this service, or ensures that is has provided the technical solution for other stakeholders or consultants to do so?

    Answer: Yes, it is expected either the awarded applicant will provide this service or enable other staff or consultants to do so.

18. **Question:** Is OHS already aware of potential issues regarding "Measuring and tracking unintended consequences of the benchmark initiative and recommending and implementing effective mechanisms for filling any data gaps required for successful implementation"? If yes, what are they? Is there a Risk Register in place for this initiative that we could access in advance of proposal submission (redacted where necessary)?

    Answer: The Cost Growth Benchmark Unintended Consequences Measurement Plan is provided here: https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/Reports-and-Updates/Unintended-Adverse-Consequences-Measurement-Plan.pdf. There is no Risk Register in place currently.

19. **Question:** If possible, we would appreciate a clarification concerning the State's answer to Question #31 in the Q&A below.
    Generally, any custom development peripheral to the Commercial Off The Shelf (COTS) product is the IP of the State. As the answer below would likely eliminate participation from COTS vendors (on-premise or offered as a service), would the State consider having ownership of any custom development external to the COTS software along with a perpetual license?

    31. Question: Will the state consider a vendor-owned SaaS solution?
    Answer: No, OHS will own the solution.

    Answer: Yes, OHS may consider having ownership of custom development external to COTS product with a perpetual license.