STATE OF CONNECTICUT
OFFICE OF THE HEALTHCARE ADVOCATE
STATE INNOVATION MODEL PROGRAM MANAGEMENT OFFICE

REQUEST FOR PROPOSALS (RFP)

HEALTH ENHANCEMENT COMMUNITY CONSULTATION

The State Innovation Model (SIM) Program Management Office seeks consultation services to support the State in planning for a new Health Enhancement Community initiative as part of Connecticut's broader SIM strategy. The consultant(s) selected through this Request for Proposals (RFP) will provide subject matter expertise, strategic planning, design development, actuarial analysis, and stakeholder facilitation to support the creation of the HEC model and implementation approach. The Health Enhancement Community model will foster community-wide multi-sector collaboration and accountability to promote healthier people, better care, smarter spending, and health equity.

This is a competitive procurement for one or more contracts of approximately seven months duration. Preference is given to proposals with a single point of accountability. However, the state welcomes proposals from either a) a single bidder demonstrating the capacity to undertake all five objectives b) a partnership between a principal bidder and subcontracted consultants, or c) multiple bidders responding to a subset of the objectives. The anticipated combined maximum award is $1.2 million. The resulting contract may contain an option to renew at the State's discretion to support additional planning, financial analysis or technical assistance.

http://www.biznet.ct.gov/SCP_Search/BidResults.aspx

Applicable Dates:

RFP Release Date	**10/20/17**
Letter of Intent to Apply (optional) Due Date:	**11/3/17**
Application Due Date:	**12/01/17 1pm Eastern Time**
Anticipated Issuance of Notice of Award:	**12/15/17**
Anticipated Period of Performance:	**1/1/18 – 7/31/18**

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1 EXECUTIVE SUMMARY

The Health Enhancement Community (HEC) initiative is part of Connecticut's comprehensive SIM strategy to promote healthier people, better care, smarter spending, and health equity. The consultant selected through this Request for Proposals (RFP) will provide subject matter expertise, strategic planning, design development, actuarial analysis, and stakeholder facilitation to support the creation of the HEC model and implementation approach.

For the purpose of this RFP, the state has established the following provisional definition:

> *A Health Enhancement Community is accountable for health, health equity, and related costs for all residents in a geographic area; uses data, community engagement and cross sector activities to identify and address root causes; and operates in an economic environment that sustainably funds and rewards such activities by capturing the economic value of improved health.*

Any questions related to this grant program should be directed to:

Faina Dookh:
Faina.dookh@ct.gov

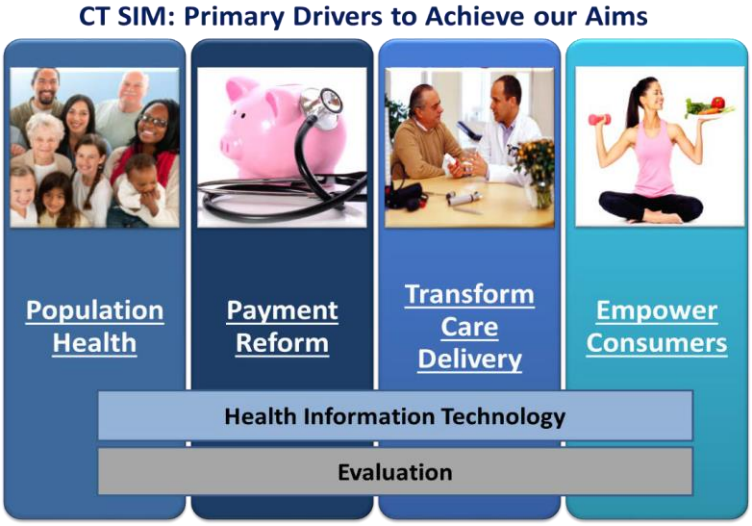
Applications must be submitted electronically on or before the date indicated below to:
Faina.dookh@ct.gov

RFP Name	Health Enhancement Community Consultation
RFP Release Date	October 20, 2017
Electronic Location of Request for Proposals	http://www.biznet.ct.gov/SCP_Search/BidResults.aspx
Letter of Intent (optional) Due Date	November 3, 2017
Request for Proposals Application Due Date	**December 1, 2017 at 1pm**
Anticipated Notice of Award	December 15, 2017
Period of Award	January 1, 2018 – July 31, 2018
Anticipated Total Available Funding	$1.2 million
Anticipated Number of Awards	One or two awards
Eligible Applicants	Consultants with expertise in operational and strategic planning, facilitation, cross-sector community health improvement, stakeholder engagement, actuarial and health economic modeling, and payment reform.

2 BACKGROUND INFORMATION

2.1 CONNECTICUT'S STATE INNOVATION MODEL

The State Innovation Model (SIM) initiative is a Center for Medicare & Medicaid Innovation (CMMI) effort to support the development and implementation of state-led, multi-payer healthcare payment and service delivery model reforms that will promote healthier people, better care, and smarter spending in participating states. In 2014 Connecticut received a $45 million State Innovation Model (SIM) grant from CMMI to implement a multi-faceted strategy to improve the health outcomes and healthcare spending trajectory of the state, as well as to improve the sizeable health disparities that continue to persist. Over a four-year period (2015-2019) Connecticut's SIM proposes to improve Connecticut's health system for the majority of residents.



We are investing in a transition away from paying for a volume of healthcare services towards paying based on whether people receive high quality care with lower growth in costs. This includes funding the design and launch of the state's first Medicaid Shared Savings Program ("PCMH+"), which rewards healthcare providers for improved quality outcomes and better cost trends.

We are providing technical assistance and supports to healthcare providers that want to succeed in these new payment models, so that they can connect individuals to community and behavioral supports, deploy community health workers, use data to track and improve their performance, and more. Providers access these resources through our Advanced Medical Home and Community & Clinical Integration Programs.

Simultaneously, we engage consumers by promoting insurance plans that remove financial barriers to, or introduce rewards for preventive care, medication adherence, chronic disease management, and high-quality provider selection. We promote these "Value-Based Insurance Designs" by convening employers and creating easily adoptable templates and disseminating best-practices.

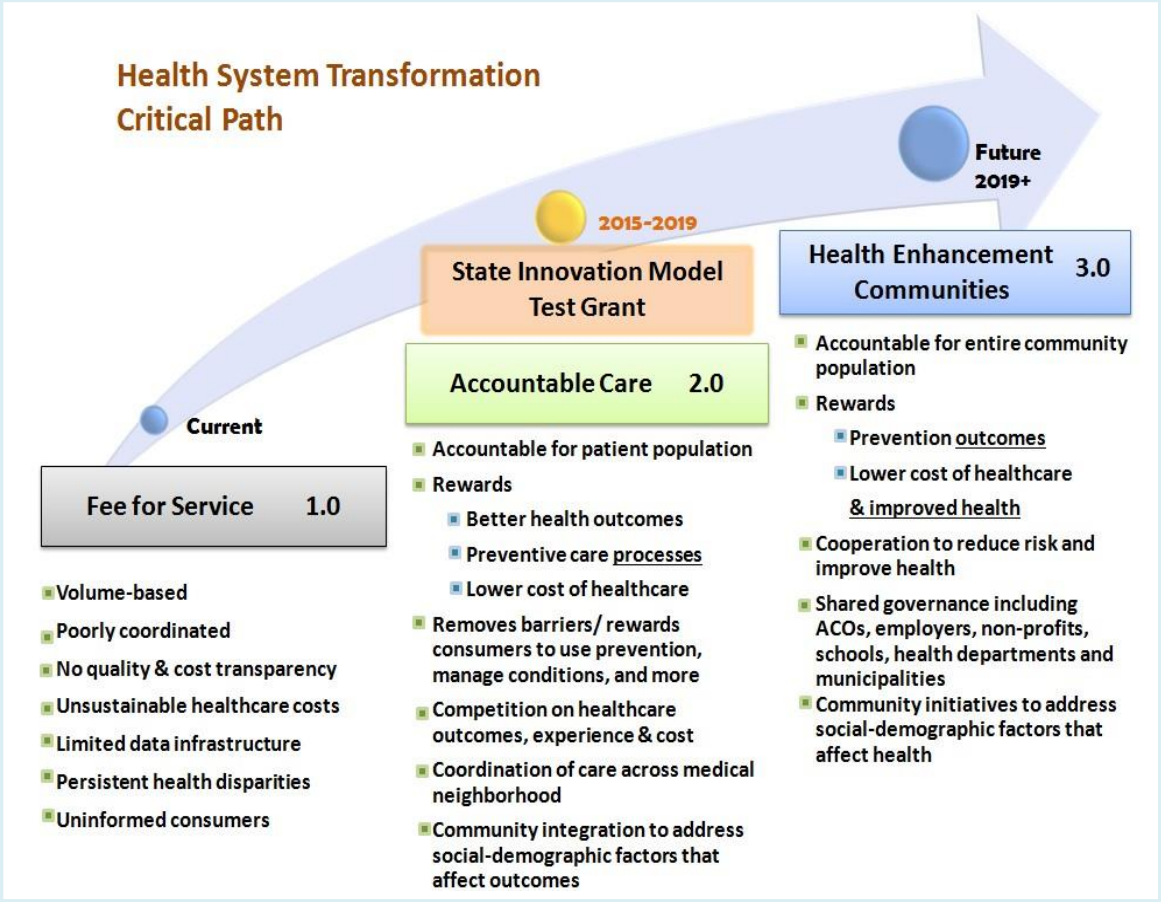
Lastly, we are developing and testing components of a Population Health Plan, which is to be completed and implemented before the end of the SIM test grant period. This longer-term strategy will combine innovations in clinical healthcare delivery, payment reform, and population health strategies to improve health as a community approach, rather than one focused solely on patient panels.

Over the last year, the population health planning efforts have focused on designing and launching the Prevention Service Initiative (PSI). This initiative aims to increase the number of contracts between CBOs and ACOs for diabetes and asthma self-management programs by providing technical assistance.

The State is now turning its attention to developing and implementing the **Health Enhancement Community Initiative.** This initiative is our most ambitious project under this population health effort.

Connecticut's SIM moves Connecticut's health care system along a path of transformation. The HEC model is intended to build on and extend many of the current SIM investments and aims. See the diagram below, which aligns with Neal Halfon's Transformation Framework,[1] particularly the highlighted sections which articulate much of what we are seeking to solve for in the HEC planning process. The next section provides the context for the HEC initiative.

Please also note the following regarding Connecticut-specific public health and community related information: Community Health Collaborative scan 2017, Population Health Council Environmental Scan, CT Prevention Programs, NCD Policy Scan, CT Community Health Needs Assessments.



[1] *See highlighted sections* of Halfon (2014) report

2.2 Health Enhancement Community Initiative

Connecticut's State Innovation Model is implementing a range of care delivery and payment reforms to improve health care and slow the growth of healthcare spending. However, taken alone, these are not enough to make Connecticut a place where preventable deaths, diseases, and health disparities are eliminated and every person enjoys the best health possible. To achieve these ambitious goals, Connecticut's SIM will partner with communities to design a Health Enhancement Community initiative that moves beyond treating illness, to address root causes, behavior, and social determinants of health.

Connecticut is proposing to create the conditions that promote and sustain cross-sector community-led strategies focused on prevention. A *provisional* definition to begin the planning process was developed:

> *A Health Enhancement Community is accountable for health, health equity, and related costs for all residents in a geographic area; uses data, community engagement and cross sector activities to identify and address root causes; and operates in an economic environment that sustainably funds and rewards such activities by capturing the economic value of improved health.*

Many components of the HEC definition are intentionally undefined in order to accommodate a thoughtful, community-driven planning process.

More Needs to be Done to Shift the Focus to Prevention

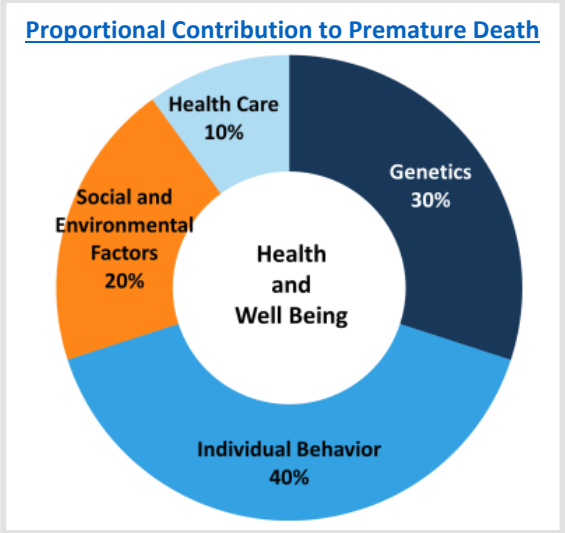
More than half of all Americans suffer from one or more chronic diseases, and obesity, a precursor to many chronic diseases, is contributing to lower life expectancy. Health disparities around chronic conditions also persist—people of color face higher rates of diabetes, obesity, stroke, heart disease, and cancer. A study by the Milken Institute calculated that seven chronic conditions are costing the U.S. economy more than $1 trillion per year. In fact, chronic conditions drive 96% of Medicare costs and 83% of Medicaid costs and are responsible for two thirds of the rise in overall healthcare costs since 1980.

Despite the fact that 40% of cancer, 80% of heart disease, and 80% of type 2 diabetes are preventable, the rates and costs of chronic conditions are predicted to continue to rise significantly over the coming years.

Bringing Everyone to the Table

Preventing chronic disease is beyond the reach of any one sector of the community. Inadequate healthcare, for example, contributes about 10% to a person's chances of dying prematurely. Moreover, prevention in healthcare is difficult in the current "sick care" system. Even in the most advanced alternative payment models, preventing chronic disease is not rewarded.

Health behaviors, such as smoking and diet and exercise, are the most important determinants, contributing 40% to the risk of



premature death. Improving health also depends heavily on addressing the non-behavioral determinants of health– the conditions in which people are born, grow, work, live and age.

Working together, the business, municipal, educational, social service, public health, and healthcare sectors can influence both behavior and the social determinants of health. Local organizations and community members themselves know best what the challenges are of their communities and how to approach them.

Research validates that preventable deaths have been reduced when comprehensive multi-sector networks undertake health improvement initiatives. National efforts have also emphasized cross-sector initiatives. For example, Accountable Communities for Health (ACH) (e.g., CHCS report, NASHP report) are coming to the forefront in many states. National efforts such as REACH have been shown to make an impact on health equity. In Connecticut, important local collective efforts are occurring that are forming the foundation for planning HECs including multi-sector collaboratives to identify and prioritize the most pressing health needs in a community.[2]

Why Setting the Table is Not Enough

Despite increased awareness of health disparities and a broad range of societal efforts to improve the health of populations, little progress has been made in reducing social gaps in health.[3] In fact, current Accountable Communities for Health (ACH) models often do not focus on upstream prevention that can lead to broad improvements in health and health equity. Several of the biggest challenges to ACH models around the country include data and measurement infrastructure, clear governance schemes, and the lack of long term financial sustainability.

The State can play a critical role in supporting communities and facilitating solutions to these challenges. Bringing stakeholders together without addressing such barriers that prevent communities from fully enacting and sustaining a prevention strategy is not likely to curb the rising rates of chronic disease. For example, the State can 1) assist communities to establish a framework for measurement and accountability, 2) support the development of local multi-stakeholder alignments and locally tailored governance structures and 3) solve for financial sustainability by defining, demonstrating and capturing the value of improved health due to prevention and create conditions that attract investments and innovations in prevention.[4] Financial sustainability solutions may include but are not limited to market-oriented-solutions, public-private partnerships in financing or development of wellness trusts.

[2] Community Solutions initiative in N. Hartford, The Vita Health and Wellness District in Stamford, Healthier Greater New Haven Partnership, Primary Care Action Group in Bridgeport, coalitions to complete Community Health Needs Assessments, and others

[3] Williams, D.R., Costa, M.V., Odunlami, A.O., and Mohammed, S.A. Moving Upstream: How Interventions that Address the Social Determinants of Health can Improve Health and Reduce Disparities. J Public Health Manag Pract. 2008; 14(Suppl):S8-17

[4] See Appendix 1, page 51, https://www.surgeongeneral.gov/priorities/prevention/strategy/report.pdf

SIM Governance

The planning and execution of the HEC initiative will be done through extensive engagement with a broad array of people and sectors, inside and outside of government, and in communities. The Lieutenant Governor provides overall leadership and oversight for SIM. The SIM initiative is executed in collaboration with multiple agencies and organizations including the Department of Public Health, the Department of Social Services, the Office of the State Comptroller, Access Health CT, UConn Health, and others. The SIM PMO, within the Office of the Healthcare Advocate, is leading the implementation of SIM. The PMO coordinates activities across work streams, engages stakeholders, manages vendors, executes care delivery reform initiatives, and communicates progress to the public.

The PMO engages more than 150 stakeholders through a number of advisory councils that focus on particular components of SIM such as quality measurement, practice transformation, value-based insurance design, and population health. These councils are comprised of consumers, employers, healthcare providers, community organizations, and subject matter experts. The Population Health Council will play a key advisory role for the HEC initiative, and will be engaged throughout the planning and implementation process. Over the past year, the Population Health Council has advised on the development of the Prevention Service Initiative. It will now change its focus to advise primarily on the HEC initiative. Councils make their recommendations to the Healthcare Innovation Steering Committee (HISC), which provides key guidance on the direction of SIM. The HISC will also be actively engaged as part of the HEC initiative.

The HEC initiative and planning efforts are being jointly administered by both the PMO and DPH. The two parties will also jointly direct the contract(s) resulting from this procurement.

3 REQUIRED SCOPE OF WORK AND QUALIFICATIONS

3.1 SCOPE OF WORK

Below we outline five high-level objectives of the HEC initiative. We also inventory the activities that the resultant consultant will undertake to support the State in meeting these objectives. These activities are not meant to be comprehensive and may evolve as the planning work unfolds. The State welcomes the incorporation of the Respondent's ideas in their response.

We recognize that this scope of work requires a wide range of capabilities. While the State prefers a single contract and point of accountability, the state welcomes proposals from a) a single bidder demonstrating the capacity to undertake all five objectives b) a partnership between a principal bidder and subcontracted consultants, or c) multiple bidders responding to a subset of the objectives.

OBJECTIVE 1: There is an innovative, logical, clear, and actionable strategy to support and enable HECs in Connecticut's communities.

1. Synthesize the Connecticut-specific problems the initiative addresses and what success looks like.
2. Recommend the role of key sectors in enabling HECs to succeed, including potential governance structures, sources of infrastructure support, management resources, fiduciary functions and coordinating activities. This includes identifying the respective role and functions of the State and participating communities.
3. Recommend community-wide process and outcome measures and methods for producing such measures as a means to monitor HEC performance; such measures must be sufficiently reliable and valid to serve as the basis for accountability agreements and the distribution of financial rewards. The recommendation should include a solution for community-wide attribution (i.e., the population with regard to which the HEC performance will be measured).
4. Recommend one or more financial models and a plan for implementing such models that would provide financial resources up-front to plan and implement cross-sector activities and sustain such activities ongoing. Such models should, at a minimum:
    a. Enable near term investments in infrastructure and cross-sector activities;
    b. Rely primarily on public and private sector investments and contributions, rather than grants;
    c. Provide rewards to HECs and other contributors/investors:

- proportionate to the economic value of health improved considering the tangible and intangible value produced in the healthcare sector as well as other sectors such as private and public sector employers, municipalities, and state agencies such as corrections and child welfare;
- taking into consideration the extended return on investment timeframes characteristic of root cause preventive interventions;

5. In support of #4 above, consider promising options for financing root cause solutions such as those identified in the RWJF report and CDC report. The examination shall, at a minimum, include but not limited to the following:
   - Capture and reinvest
   - Blending and braiding federal, state and local funds
   - Community benefit financial institutions
   - Hospital Community Benefit
   - Prevention escrow account
   - Low-income housing tax credits
   - New Markets Tax Credit
   - Pay for Success/Social Impact Bonds
   - Wellness Trust
   - Captive insurance
6. Identify and review the range of existing value-based payment models, with special attention to existing Connecticut models, and recommend adjustments to such models that would promote investments in prevention.
7. Recommend statutory and regulatory levers and various federal authorities (e.g., Medicare or Medicaid waivers) that would be required to implement the solutions recommended in #4, 5, and 6 above.
8. Recommend health information technology enablers that would enable the success of HECs and federal opportunities to finance such enablers, in consultation with the State's Health Information Technology Officer (HITO).
9. Recommend levers regarding workforce.

OBJECTIVE 2: The HEC strategy is designed using a community-driven process that is relevant to and has strong buy-in from a diverse set of stakeholders.

1. Implement an ongoing stakeholder engagement and communication strategy. This strategy should, at a minimum:
   a. Allow for community members, existing collaboratives, healthcare providers, employers, community organizations, municipal government representatives, and others to be active participants and co-creators of the ultimate HEC approach.
   b. Special emphasis should be placed on garnering the input and engagement of individuals and organizations that represent or serve populations with demonstrated health disparities.
   c. Engage state experts in insurance and health economics and private and public universities.
   d. Engage federal officials such as at CMS, CMMI, and HRSA as needed.

e. Communicate progress on a periodic basis, translating complex ideas into simple, clear messages for broad dissemination.

f. Propose a feedback process where HEC components and recommendations are continuously vetted and adjusted as part of the stakeholder input process.

2. Support the State in engaging state agencies and statewide organizations (e.g., foundations) in the planning process. This may include preparing background materials, organizing meetings, preparing summaries, and serving as subject matter experts.
3. Work with a cohort of no less than three reference community health collaboratives that meet a minimum state of readiness in order to engage in a problem-solving partnership for designing the HEC strategy and to illustrate how the recommendations from Objective 1 might be realized in a Connecticut-specific community. Jointly, with the reference communities as planning partners, the planning should examine barriers and opportunities related to governance, management, infrastructure, data, measurement and financing with respect to cross-sector health and prevention activities. The planning partners should examine existing sources of funds that are currently used to subsidize such activities or that could be leveraged as part of a braided or blended funding solution. The planning partners should also examine potential sources of investment capital that may be accessible to members of these communities.

OBJECTIVE 3: The State can quantify the magnitude of the economic opportunity associated with health improvements that may be undertaken by HECs.

1. Propose and conduct financial modeling using Medicare data contained in the Connecticut All Payer Claims Database to project the potential savings associated with various health improvement scenarios over a 2, 5, 10, 15 and 20-year timeframe. The analysis should focus primarily on the economic benefits of health problems avoided (i.e., a reduction in the incidence and prevalence of acute and chronic illness and injury) as a result of primary and upstream secondary prevention. The analysis should examine non-disease specific approaches to quantifying value creation such as impact on population risk trend as reflected in HCC risk scoring. The analysis should not focus on savings that accrue from improvements in clinical management, as is typical of most value-based payment models.
2. Produce a flexible financial modeling tool using Medicare data that enables state planners to modify assumptions and assess associated economic impact.
3. Recommend companion analyses that may be undertaken by the State and its private partner payers with respect to Medicaid, state employees, and commercially insured populations in order to produce a complete, statewide view of the potential economic value of health improved.
4. Propose and conduct analyses with respect to other state agency service expenditures to which health improvement benefits would likely accrue in corrections, juvenile justice, education, housing, and child welfare.

5. Work with 2-3 employers to model the potential value of prevention efforts as it relates to productivity (e.g., presenteeism & absenteeism).

OBJECTIVE 4: Input from the Population Health Council and the Health Care Innovation Steering Committee (HISC) is incorporated into the HEC initiative, and there is adequate buy-in from members.

1. Engage the HISC and Population Health Council in the formulation of an HEC vision and associated Population Health Council charter, which will serve as a frame for the advisory process.
2. Facilitate in-person, monthly Population Health Council meetings including the following:
    a. Preparing meeting agendas, presentation materials, and background materials; facilitating the discussion; conducting presentations; creating a structured and logically sequenced timetable.
    b. Arranging for presentations and/or illustrating local experiences that feature related work in Connecticut and in other states.
3. Provide periodic presentations to and solicit input from the HISC.

Note well: The consultant(s) should plan to facilitate 7-10 meetings of the Population Health Council, which is expected to meet no less than monthly during this intensive planning process. The consultant(s) should plan to address the HISC on three to four occasions through the conclusion of the planning process. The HISC usually requires two meetings to review and approve a final plan including a period of public comment.

OBJECTIVE 5: Summary Report and Plan.

1. Produce a concise and clear report including, at a minimum, background, key findings, and recommended HEC initiative strategy consistent with the advice of the Population Health Council and HISC.
2. The report should contain a summary of the community engagement status including an illustration of a hypothetical future state. The future state should provide an *applied view* of the proposed strategy if it were implemented and fully realized in these reference communities.
3. Propose a detailed plan with timelines, milestones, etc. that operationalize key components of the HEC initiative.