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REQUEST-FOR-PROPOSALS STATE OF VERMONT

HOSPITAL PAYMENT SYSTEMS CONSULTATION

RESPONSES TO QUESTIONS

July 14, 2006

1. Question: You specifically discuss a DRG payment approach in the RFP, but you also ask that the paper describe approaches used in other states. What payment systems do you expect to see implemented? Acute Care DRG or Acute Care Cost per Case? Acute Care APG or Acute Care RVU? Separate systems for Psych? Rehab? Transplant? Any other carve outs?

Response: The purpose of this proposed engagement is to create a new hospital reimbursement system. The State has not predetermined the specifics of the system, although a DRG payment system is currently the preferred option. Whether there are carve outs or separate systems for psychiatry are to be determined based on analyses and assessments to be performed by the contractor.

2. Question: How will you know if the changes are successful? Hospital payments increase? Hospital payments stay the same? Hospital payments spend the same but differ from where they now are? How much change is acceptable? Hospital spending decreases? Other measures?

Response: The RFP stipulates the proposed system should be cost neutral. The RFP states that the “payment system should be designed so as to be budget neutral based on projected expenditures for the State fiscal year in which it is to be implemented. The payment system should encourage economy and efficiency in the delivery of services.” See also response to Question 44.

3. Question: Which agency will guide day-to-day efforts? Any person/people in particular?

Response: The person who will direct day to day operations will be Nancy Clermont, Deputy Director, Office of Vermont Health Access. In addition, John Dick, Director of Reimbursement will be involved and a frequent contact at OVHA for technical support, background and assistance in obtaining data.

4. Question: Will an Advisory Group be involved? Who's on it? What is their role?

Response: There will not be a specifically designated advisory group created for this project other than the Vermont Association of Hospitals and Health Systems (VAHHS) group identified in the RFP. This is a group of hospital representatives who will meet periodically to solicit input, provide information and feedback on issues related to the changes contemplated, the timetable, and to discuss changes in approach that have been made based on input that was previously provided.

5. Question: Will a Legislative Group be involved? Who's on it? What is their role?

Response: It is expected that the proposed changes in the hospital payment system will be reviewed by the Health Oversight Committee (HOC), a standing Committee of the House and Senate. The HOC is appointed at the start of each biennium (January 2007). The Contractor will be expected to prepare the presentation(s) that will be made to that Committee and participate in them. It is unclear if there will be more than one presentation, but for bidding purposes up to three meetings should be budgeted. It is also expected that a presentation will be made to the Medicaid Advisory Board, with similar expectations of the Contractor (budget 1 meeting).

6. Question: What Department staff resources will be available to assist? How much available?

Response: See response to question 3. If it is necessary to assign additional OVHA resources to this project, it will be done by the Deputy Director. It is expected the EDS, the State's MMIS contractor will provide the contractor with necessary data from their files and be directly involved in the implementation of system changes.

7. Question: Clinical Data

Given PCCM, what data exists (years, format, completeness) at the patient level for: Inpatient, Outpatient, Emergency Room, Ambulatory Surgery? What fields are on these records? Do data differ by instate/out-of-state? How complete (compliance) are the individual fields? Have the IP claims been grouped? Which grouper? What are the frequencies of the DRGs? Have the OP claims been grouped? Which grouper? What are the frequencies of the APGs/RVUs?

Response: PCCM has had no impact on the availability of data as all PCCM claims are processed by the State's MMIS contractor, EDS. All claims fields that are captured and stored will be available. The State requires submission of claims using the standard

claims forms, UB 92 and the HCFA 1500. None of the claims have been grouped, as this is not required in the current cost based outpatient and per diem inpatient systems.

8. Question: Facility Data

What Cost Report data at the facility level exist? What's the format/layout? How current is the data, do you expect any changes in the future?

What Hospital Survey data at the facility level exist? What's the format/layout?

How current is the data, do you expect any changes in the future?

What other relevant data sets exist that might help this effort?

Response: Medicare hospital costs reports are available from the Medicare auditor. The most recent audited cost reports are for 2003 and some for 2004. The format for cost reports follows Medicare requirements. Also complete hospital budget data are available from the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA). They include proposed, current, and audited budget data for the most recent year using a standard BISHCA format. Historical hospital budget data is also available from BISHCA. The reference to Hospital survey data is unclear and is not addressed.

9. Question: Expenditure Data

What are the existing payment categories, qualifying criteria, payment formulas?

What are the historical spending levels by payment type?

1. IP
2. OP
3. DSH
4. Adjustment
5. Other

What are the historical eligibility data by eligibility class?

What are the historical spending by eligibility class by payment type?

Will you provide projections as well as history?

The State of Vermont has entered into a creative and comprehensive reform in its Global Commitment program. This RFP is part of that program. How does this RFP fit within this overall program? What are its specific goals? What would you desire to happen to spending levels within the hospital program? patient eligibility and consumption by eligibility class? How do these expectations compare with historical spending levels by payment type and consumption by eligibility class?

What are the specific current payment formulas and qualifying criteria for each payment type?

Response: See page 4-5 of the RFP for data on hospital payments. Since this engagement does not contemplate a payment system based on eligibility class, the State has not chosen to respond to this question. If it becomes central to the work of the contractor, this data can be provided.

Historical data as well as spending projections are available. However, projections for future hospital spending are always subject to changes in enrollment, policy changes, and other factors. Since the current payment methodology is now over 15 years old and is based on cost studies completed in the late 1980's and early 1990's, the State believes it is necessary to develop a more contemporary system that more adequately and equitably reflects the delivery of hospital services to enrolled beneficiaries and further promotes the delivery of services in an economical manner. Like all state Medicaid programs, the State is interested in reducing the growth in expenditures in the aggregate and on a per beneficiary basis. Although this can not be accomplished through reimbursement system changes alone, the various provider sector payment systems should contribute to the objective to the extent possible. Consequently, up-dates to the hospital payment system should be consistent with this goal.

10. Question: Financing Data

What are the historical sources of funds used to support spending (GRF, provider taxes, grants, etc.)?

How are these expected to change over the next few years?

Response: Hospital services are financed by provider tax revenues, provider donations, tobacco product taxes, and legislative appropriations. The sources of revenues are not expected to change in the near term.

11. Question: Payment Limits

What analysis has been done on the UPL? Why do you state that there is a problem here?

What analysis has been done on the DSH cap?

Are these limits expected to change over the next few years? How?

Response: It has not been determined if the payment methodology changes that result from this project will require CMS approval. (See also response to Question 97) However, any modification in the payment rates is accompanied by an assessment as to whether the rate results in payments that are at or below the UPL. The most recent analysis was done in 2006. The State's understands that the current Medicare outpatient reimbursement methodology may be reimbursing below Medicaid allowed costs as determined through the cost reports. Since the State's current outpatient payment methodology reimburses based on a portion of allowed costs as determined through the cost reports, payment at cost might result in payments in excess of the UPL. This engagement is designed to determine if this is correct.

12. Question: The RFP states (page 4): "Outpatient hospital services, except lab and x-ray are reimbursed based on a percentage of allowable costs as determined by the audited Medicare cost reports. Interim payments are paid based on a percentage of charge prior to cost settlement. Calculations made during recent changes in hospital payment methods set out in the Medicaid State Plan suggest that payment at 100% of Medicare allowable

costs may be inconsistent with CMS Upper Payment Limit requirements.” Can you please explain further this statement? Several states use a Medicare allowable cost methodology to compute the UPL. Exactly which CMS UPL requirements have been changed? Where can we find documentation to support this statement?

Response: See response to question 11.

13. Question: The RFP indicates Vermont Hospitals pay a provider tax of 6% on net revenues. Will the work under this project involve any exploration of modifications to the tax in terms of possible waivers of the broad based and uniformity requirements?

Response: This is not contemplated as part of this engagement, but the State is very concerned about the CMS proposed reduction of the tax cap from 6% to 3%. If there are proposed methods to address this, the State would be interested in bidder proposals in this regard. If bidders address this in their bid proposal, please separately identify the costs associated with this proposed work and describe in detail the work to be completed.

14. Question: Are there restrictions in the tax legislation regarding the use of the tax funds? We are particularly interested in any designated payments to hospital providers coming from provider tax financed Medicaid funds.

Response: There is no restriction on the use of provider tax funds, other than that they fund payments made under the Medicaid program. The State works to ensure that provider tax payments support the relevant provider sector.

15. Question: Does Vermont have any arrangements with public hospitals for IGTs or CPEs or special DSH payments that need to be considered in modifying the allocation of current payments among hospitals?

Response: No. There are no public hospitals in Vermont that will be affected by this engagement. The only public hospital is the Vermont State Hospital and it is not currently eligible for Medicaid payments.

16. Question: What is the contract period for the fiscal intermediary relative to the period for this contract? We want to make sure we understand if and when a change in fiscal intermediaries may impact the change in reimbursement systems.

Response: The State’s FI will not change during the period of this engagement.

17. Question: The RFP states: “Since there will be no opportunity for Bidders to revise the pricing, and there will not be a Best and Final Offer (BAFO) process, the Bidder should carefully calculate and propose its prices for the services requested herein.”

It is our experience that complex projects like this often involve changes initiated by the purchaser prior to finalizing the contract. Is it correct for us to assume that changes that come about in negotiation of the final terms and conditions of the contract (e.g., the

contractor wants more or less on-site time that affects travel costs) may result in changes in the final contract amount?

Response: Yes, this is possible.

18. Question: The Policy paper including the relative weights must be done by February of 2007. The Final paper is due October 1, 2007. That seems to imply actual implementation sometime after 10/1/07. Medicare's DRG grouper changes are effective each October 1st. Does the State intend to conform to the Medicare implementation schedule? If so, does the State expect the vendor to develop weights for the policy paper using Medicare's FY 2007 grouper and then recomputed new weights based upon the Medicare FY 2008 grouper for the final report?

Response: Actual implementation will begin on or after 10/1/07, which coincides with the start of each hospital's fiscal year. It has not been determined at this point in time if both the new inpatient and outpatient systems will begin on 10/01/07. If the State adopts the equivalent of the Medicare outpatient system for Medicaid payments, the State would intend to conform to the Medicare update schedule. If so, the State would likely expect the vendor to develop weights for the policy paper using Medicare's most current grouper and then recomputed new weights based upon the actual year of implementation. See also responses to Questions 23, 46, 71, 96 and 101.

19. Question: It appears that the State is looking for a single price for evaluation purposes. The defined work all appears to be done in the first year of the contract with the second year handled per the RFP as:

“The duration of the contract commences on execution and extends through June 30, 2008. The scope of work may be modified effective October 1, 2007 or upon implementation of the new payment system, whichever is later. This change will be based in the needs of the State for professional services related to the payment system for approximately one year post implementation. There may also be an additional one (1) or a two (2) year extension beyond June 30, 2008 at the discretion of the State.”

It is unclear what the “price” should include”. Is it the work period ending October 1, 2007? Is it the work leading up to the implementation of the new payment system (which could be later than 10/1/07)?

Response: The bid proposal should be based on an assumption that a new reimbursement system will be implemented 10/01/07. The bid proposal should identify the scope of work to be completed between 10/01/07 and 6/30/08 (post implementation), including associated costs. Consequently, the price proposal should include costs for work through June 2008. See also responses to Questions Also see responses to Questions 38, 39, 72, 73, 82, and 100.

20. Question: Is this a fixed price contract or time and materials up to a ceiling?

Response: The State contracts are structured to function as time and materials contracts up to a ceiling (maximum amount of the contract).

21. Question: Will the State accept a payment schedule where time and material charges are billed by the contractor and reimbursed by the State on a monthly basis?

Response: Yes. Contractor invoices are expected to be submitted monthly. The State would pay monthly based on an invoice submitted by the contractor that reflects incurred costs for the month billed.

22. Question: Will the State accept a payment schedule where 1/12 of the first year contract amount is billed and reimbursed monthly?

Response: No, but contractor invoices are expected to be submitted monthly based on costs incurred in the billed month.

23. Question: What is the timing and priority of inpatient versus outpatient payment transition? Is OVHA planning to implement changes simultaneously?

Response: A determination has not been made on the timing and priority of inpatient versus outpatient payment transition. This would be articulated in the policy paper and be part of ongoing discussion with OVHA. OVHA's goal, however, is to implement changes effective 10/01/07. See also responses to Questions 18, 46, 71, 96 and 101.

24. Question: How is the "Choices for Care" program coordinated with mainstream 1115(a) waiver programs for the purpose of this project? Will reimbursement change universally? (p.3)

Response: Hospital payments for beneficiaries enrolled in the "Choices for Care" long term care waiver program are not included in the budget for that program, but are in the Global Commitment waiver budget. To the extent possible, the reimbursement system should not create an incentive for the hospitalization of LTC patients in lieu of more appropriate alternatives.

25. Question: Why did the state take over management from the managed care plans? When did this occur? (p.3)

Response: One plan left the State and the State was unable to negotiate acceptable rates with the remaining plan. This occurred between October 1998 and January 1999.

26. Question: How is the provider tax accounted for under the current payment system? (p.21)

Response: The hospital provider tax is used to support DSH payments and a portion of the per diem for Vermont hospitals only.

27. Question: Does OVHA have tools or criteria determined for evaluating the information provided in the policy paper or will vendor be required to make a recommendation? (p. 21)

Response: The State will expect recommendations from the vendor. The policy paper will not be developed in a vacuum, but will result in ongoing discussions with OVHA staff and providers.

28. Question: Are hospital representatives already aware of this impending project? (p. 22)

Response: Yes, the Vermont Association of Hospitals and Health Systems (VAHHS) has been apprised on this RFP.

29. Question: Will the hospital meetings be held in one location? (p. 22)

Response: This is the expectation, but locations may change based on the actual scheduling of meetings and the needs of the participants. Most likely meetings will be held either in Montpelier or Williston, Vermont.

30. Question: Will critical access hospitals be given the choice to participate in the new payment system? (p. 22)

Response: No, as CAHs are reimbursed based on current per diem rates. It is possible that a separate system could be developed for CAHs however.

31. Question: What percentage of inpatient cases and dollars was consumed by outliers in FY05? How are outlier cases reimbursed in the current system? (p. 22)

Response: The State does not make outlier payments in the existing system.

32. Question: What differentiates ICU from ICU-Other under the inpatient admission types? (p. 34)

Response: The accommodation types are mapped to revenue codes. Standard ICU care is mapped to ICU while CCU or NICU, for example is mapped to ICU other.

33. Question: Besides the Medicare Cost Reports, are there any other regulatory reports containing hospital cost data in Vermont?

Response: See response to question 8.

34. Question: Is project funding guaranteed in the 2007-2008 appropriation period? If not, what goals are expected to be accomplished in the 2006-2007 period as opposed to the 2007-2008 appropriation period? (Attachment C, 1)

Response: Project funding is part of the SFY 2007 budget. It would be highly unusual for the State to abandon a project of this importance at the end of SFY 2007. However, please note that the RFP states, on page 23, "If the contract extends into more than one fiscal year (July 1 to June 30), and if appropriations are insufficient to support the

contract, the State may cancel at the end of the fiscal year, or otherwise upon the expiration of existing appropriation authority.” Project goals after July 1, 2008 will be determined by the State and negotiated with the contractor if there is a contract extension for the period 7.01.08 to 6.30.09.

35. Question: There is no Section II-E listed in the proposal. Was the bolded text “References” on Page 16 of the RFP intended to be this missing section and should we complete our proposal as such?

Response: Yes, “References” was supposed to be labeled as section II-E.

36. Question: Attachment C, Provision 15 says that “All written reports prepared under this contract will be printed using both sides of the paper”, does this provision need to be met for the proposal bid as well?

Response: This is the preferred format for the bid proposal.

37. Question: Do bidders need to have a current Vermont Business Identification Number in order to bid on this RFP?

Response: No, but a Vermont Business Identification Number will be required for any contract. However, a Tax Certification should be submitted with the bid proposal. The required form is attached.

38. Question: As a professional consulting firm, we typically prepare detailed cost proposals that identify the hourly rate and proposed hours per task for each project team member. To the extent that there are costs outside the hourly rates (e.g., travel), we typically provide an explanation of how these costs were estimated. Would this format be an acceptable, alternative format to the one listed on Page 18 of the RFP?

Response: Bidders may modify this format if it will improve the presentation and understanding of their cost proposal. However, Bidders should be certain to include all the required information in cost proposal. See also responses to Questions 19, 39, 72, 73 82 and 100.

39. Question: If the cost proposal format proposed in the previous question is not sufficient, would it be acceptable to submit hourly rates and the number of hours by staff level in lieu of providing a breakdown of base costs (e.g., salary and fringe benefits)?

Response: Fringe benefit costs can be identified as a standard percentage of salary for all personnel. See also responses to Questions 19, 38, 72, 73 82 and 100.

40. Question: The technical requirements (Section III-B) of the RFP on Page 23 indicate that Contractor will be responsible for preparing a final report that includes a “detailed description of the new methodologies.” Please confirm whether the “description of new methodologies” would include final rates.

Response: Yes, it is most likely that the final report will include rates for the first year of implementation.

41. Question: In Section II-B on page 15 of the RFP, the State requests “annual financial reports for the past three (3) years for the Bidder and any subcontractor.” Would it be acceptable for bidders to submit a summary of its revenues and expenses instead?

Response: Yes, as long as these are based on actual or audited financial reports.

42. Question: Are hospital cost reports, including all supplemental schedules, available in an electronic format?

Response: Some may be in an electronic format, but it is not certain that all are available electronically.

43. Question: The RFP indicates the State is seeking assistance and advice in converting the current per diem system into a DRG based payment system (p. 20).

How committed is the State to using a DRG payment system?

Is the State open to other options?

Will the State consider options for low volume hospitals?

Response: The State’s preference is to convert to a DRG payment system. However, if there are compelling reasons for another option, the State would be open to considering that option. Any viable option that OVHA has agreed to and that has been discussed with VAHHS can be included in the Policy Paper. The State will consider options for low volume hospitals.

44. Question: The State is requesting the new payment system be designed to be budget neutral (p. 21).

Is the State’s intent to be budget neutral at individual hospital level or State (aggregate) level?

If at the hospital level, Vermont hospitals only or all hospitals, including all border hospitals listed on page 5 of the RFP?

Response: Is the State’s intent at the present time to at least be budget neutral at aggregate level. See also responses to Questions 2 and 92.

45. Question: The State asks the bidders to describe their capacity to perform analyses or models necessary to assess the impact of proposed changes on hospital payments (p. 20). The State also requests that the Policy Paper include only the essential information for decision making (p. 21).

Does the State desire financial modeling of each viable option, or only the option selected by the State for implementation?

To what extent should the Policy Paper address Utilization Management, Quality Management and Pay for Performance and coordination with the Chronic Care Initiative?

Response: A determination as to which options should be modeled will be made during the engagement and in discussions with OVHA. Not every option will merit modeling. If there is a serious alternative to a DRG approach, this will need to be modeled. The Policy Paper need not address Utilization Management or Quality Management. The proposed payment system should be consistent with, or can be adapted to address, Pay for Performance and be supportive of the Chronic Care Initiative and Blueprint for Care. How this might work should be included in the Policy Paper.

46. Question: The State requests information on a Medicare-like outpatient payment system (p. 22).

Is the State committed to selection and implementation of a new outpatient system on the same schedule as the new inpatient payment system?
Does review of outpatient options imply financial modeling, or rather a review of options with their merits, weaknesses and implications?

Response: It is the State's goal to implement payment changes on 10/01/07. Depending on complexity and required system changes this could mean implementation of the new outpatient system on the same schedule as the new inpatient payment system. However, different schedules for each system are possible. See also responses to Questions 18, 23, 71, 96 and 101.

Review of outpatient options does not necessarily imply financial modeling, but rather a review of options with their merits, weaknesses and implications. However, depending on the issues associated with a new system, if it is very possible that financial modeling of the proposed system will be required prior to implementation, during the decision making process or to address hospital or legislative concerns.

47. Question: The State requests information on issues associated with incorporating IMDs into the system (p. 21).

Since federal Medicaid regulations specify that IMDs are not Medicaid-reimbursable, would you please clarify this request.

Is the State using the term IMD to encompass private psychiatric hospitals as well as psychiatric beds in a general hospital?

To what extent might the final outcome of the Vermont Futures project impact this Medicaid payment system?

Response: Federal Medicaid regulations specify that IMDs are not Medicaid-reimbursable only for those between the ages of 21-65. The Brattleboro Retreat is an

IMD and receives Medicaid reimbursement (see page 4 of the RFP) based on per diem rates for those under 21 and over 65. The State is using the term IMD to encompass private psychiatric hospitals only, not psychiatric beds in a general hospital, which are currently reimbursed on a per diem basis as a Medical/Surgical bed. The final outcome and implementation of the Vermont Futures project is likely to occur subsequent to changes made as a result of this engagement.

48. Question: Appendix 1 (p. 33) describes reductions in hospital payments in 2005 and 2006.

Please explain the circumstances around reducing inpatient reimbursement.

What percentage of hospital costs is Medicaid paying for inpatient services after the rate cuts?

What has been the hospitals' reaction to these reductions in reimbursement?

Response: The reduction in inpatient reimbursement was the result of budget constraints. It is estimated that Medicaid is paying 15 percent less for inpatient services after the rate reductions. The hospitals' reaction to these reductions in reimbursement was predictable - dissatisfaction.

49. Question: Financial modeling will require full detail level UB92 claim and payment data (billed, allowed and paid amounts) for inpatient and outpatient services, for all paid claims for the Medicaid population that is not dual eligible. The data needs to be available in electronic form at the start of the project.

Can the State assure this?

Can the data be provided on CD ROMs? If not, please provide information on which media will be available.

Response: Claims data including clinical information and payment data (billed, allowed and paid amounts) for inpatient and outpatient services, for all paid claims for the Medicaid population that is not dual eligible will be available in electronic form at the start of the project. This data can be provided on CD ROMs. The contractor needs to be aware that the current data may not be fully complete because of delayed claims submissions by providers.

50. Question: In order that we can be more responsive to your needs in the proposal, can the State provide 2 reports:

Summary of inpatient paid claims (dollars, days, admissions) by hospital, for dates of service between October 1, 2004 and September 30, 2005, for each revenue center

Summary of outpatient paid claims (dollars, claims or visits) by hospital, for dates of service between October 1, 2004 and September 30, 2005, for each revenue center

Response: Five years of claims data is on file. Claims data over five years old is archived, but does not include as much detail.

51. Question: Are Medicaid cost reports available for each hospital?

If so, for what years?

If so, are they available electronically?

If so, in what medium and format?

Response: Audited Medicare cost reports are available for all hospitals for 2003. Some audited reports are available for 2004. These are available electronically. Reports for at least three years are also available, but all may not be in an electronic format.

52. Question: The State requests a summary of payment methodologies used by other State Medicaid agencies with similar expenditures and covered lives (p. 21).

Does 'similar expenditures' mean States with similar acute care costs or similar total costs?

Does 'similar covered lives' mean total enrollees, or non-aged enrollees only?

Response: The State requests a summary of payment methodologies used by other State Medicaid agencies with similar expenditures and covered lives. The actual states to be included will be discussed with the Contractor. Similar expenditures will probably mean States with similar acute care costs, and similar covered lives will mean enrollees excluding duals if readily available.

53. Question: The RFP lists issues that should be addressed in the Policy Paper (p. 21)

Should the proposal be based on analysis and discussion of Vermont hospitals only, or all hospitals including the border hospitals listed on page 5 of the RFP?

Response: The proposal should be based on analysis and discussion of Vermont hospitals and the border hospitals listed on page 5 of the RFP.

54. Question: The State requests the Policy Paper be complete by early February, 2007 (p. 21).

Once the Policy Paper is delivered, when can we expect the State to make the decisions that will be required for work to begin on the Final Report?

Response: This is difficult to answer specifically, but the State is aware that if it intends to implement a new system(s) on 10/01/07, it needs to make decisions as soon as possible. It is expected that there will be ongoing communications with the Contractor during the engagement, so the content and recommendations contained in the Policy Paper will not be reviewed for the first time by the State in February of 2007. The contractor will also have had extensive discussions with VAHHS leading up to the completion of the Policy Paper.

55. Question: The State requests than any printed or electronic material be reviewed by the State prior to distribution (pp. 22, 24).

How much turn around time for state review and approval should we build into our plan?

Response: This might depend on the detail and complexity of the material. Two weeks would be sufficient for planning purposes.

56. Question: The State requests working with the Medicaid Advisory Board (p. 23).

Who are the participants on the Medicaid Advisory Board?
Where and how often do they meet?

Response: The MAB is made up of consumers and providers. They meet monthly, generally in Williston.

57. Question: The State requests that the consultants develop working relations with other groups designated by the State (p. 23).

How many groups does the State anticipate designating?

Response: The State does not have any specific group in mind, but with this type of engagement the State wished to remind bidders that there may be groups it needs to work with as the project unfolds. For example, there is a group of hospital financial managers who the Contractor may wish or need to meet with during the course of the project.

58. Question: The State requests that the contractor attend Legislative or Legislative Oversight Committee meetings or other meetings (p. 23).

Would the State please indicate how many meetings with legislative bodies might be required?

Response: The State is at the bidding of Legislative Committees, so this is unpredictable. However, for the purposes of the bid expect at least one, but probably not more than three. For bidding purposes, three should be budgeted, plus one with the Medicaid Advisory Board.

59. Question: The RFP states that the Contractor shall provide access to essential technical or professional staff at the Contractor's home office who are integral to the completion of the project (p. 24). We interpret this to mean that the State will be able to reach any key team member directly by telephone or email.

If that is not the meaning, would the State please clarify this requirement?

Response: That is the meaning.

60. Question: Who will be the day-to-day contact for the State?

What percentage of their time will be dedicated to working with the contractor on this project?

Response: See response to question 3. This project is a priority of the State, so it will receive time accordingly.

61. Question: The State may require oral presentation by selected Bidders (p. 12).

How much notice will the State provide to the bidders if an oral presentation is requested?

Response: Probably not a lot given the State's interest in executing a contract within the timeframes set out in the RFP, but the State will negotiate with the bidder to find a mutually agreeable time.

62. Question: We intend to submit a bid amount as instructed in the RFP (p. 18).

In our proposal, may we offer add-on options that may be desired by the State that are separately priced? For example, can we propose a summary of payment methodologies used by other States similar to VT, as required by the RFP, and also offer a summary of additional states (or rural parts of larger states) that offer instructive information from their experience for an additional fee?

Response: The State is seeking the expertise of the contractor, so incorporating instructive information from their experience with other rural states should be part of what goes into the recommendations and analysis of the Policy Paper, and should not be an add on for an additional fee.

63. Question: Does the State have a telephone conference call system or contract in place? To reduce telecommunication cost associated with this bid, will the State allow the contractor to use the conference call system/contract over the course of the project?

Response: Yes, some conferencing capacity exists at the State level. Frequently, conference calls are done at State expense, at other times at the expense of the Contractor, depending on circumstances and the number of people involved.

64. Question: Pages 3, 34. What are the current per diem payment rates for inpatient care? Are we correct that these rates are not subject to cost settlement? Overall, what percentages of hospital costs and hospital charges do these payments represent?

Response: The current per diem payment rates by accommodation type for inpatient care are:

Hospital	Type	Per Diem
CVH	M/S	935.21
	nur	388.27
	lcu	1135.50
	Psych	815.72
FAHC	M/S	1012.00
	nur	248.58
	icu	1719.33
	icu-o	2066.93
RRMC	M/S	980.95
	nur	393.45
	icu	1557.71
	icu-o	
Porter	M/S	1505.32
	nur	535.37
	icu	1432.45
	icu-o	
NoCountry	M/S	945.68
	nur	326.20
	icu	1286.57
	icu-o	
Copley	M/S	1113.68
	nur	321.73
	icu	1504.16
	icu-o	
Brattleboro	M/S	1092.48
	nur	307.23
	icu	1327.02
	icu-o	
SMC	M/S	939.76
	nur	329.86
	icu	1381.41
	icu-o	
Spring	M/S	1151.85
	nur	325.63
	icu	1738.76
	Psych	870.44
Grace Cottage	M/S	1547.97
	nur	525.10
	icu	
	icu-o	
NVRH	M/S	1134.11
	nur	326.20
	icu	1513.78
NMC	M/S	1134.11
	nur	359.94
	icu	1564.03
	icu-o	
Gifford	M/S	1331.62
	nur	511.56

	icu	1169.54
	icu-o	
Mt Ascutney	M/S	1211.48
	nur	
	icu	1146.09
	icu-o	

Out-of-State Rates	'06 Rates
Border Teaching	
M/S	776.01
nur	208.12
icu	1515.34
icu-o	1363.25
Teaching	
M/S	648.34
nur	173.88
icu	1266.05
icu-o	1138.97
80 Beds or More	
M/S	588.95
nur	251.48
icu	941.86
icu-o	n/a
Less than 80 Beds	
M/S	726.57
nur	228.17
icu	1114.69
icu-o	n/a

These rates are not subject to cost settlement. We have not estimated either the percent of cost or the percent of charge that Medicaid pays to hospitals.

65. Question: Page 4. Are we correct that DSH payment methods and levels would be outside the scope of the project?

Response: Yes, that is correct.

66. Question: Pages 4, 23. Has CMS expressed any concerns with Vermont's UPL calculations? If so, please elaborate.

Response: CMS has required complete documentation and justification that Vermont's payment rates meet the CMS UPL requirements when State Plan changes are made. CMS accepted OVHA's calculations that accompanied the recent rate reduction.

67. Question: Page 7. What companies, if any, currently advise the Vermont Medicaid program on provider payment methods and rates?

Response: There is no specific vendor that is under contract with OVHA to provide advice on provider payment rates.

68. Question: Page 8. What companies submitted letters of intent to submit a proposal?

Response: Companies that submitted Letters of Intent are identified in the attached document.

69. Question: Page 9. What companies attended the bidders' conference?

Response: See the attached list on Bidders Conference attendees.

70. Question: Page 11. Is the meeting of the proposal evaluation committee open for bidders to observe?

Response: No

71. Question: Pages 13, 23, 27. Please clarify the time frames. We understand that the Final Report will be due by October 1, 2007. Can we assume that October 2007 will also be when the State makes the decision to go forward with the new payment methods (with any changes from the Final Report as may be appropriate)? Given the interval between submission of the report and implementation of the new payment methods in the MMIS, what are the State's target dates for the new methods to go live?

Response: It is the goal of the State to implement the new payment systems effective October 2007. Any decision to go forward with the new payment methods will of necessity be made in advance of that date. The final report will provide all the necessary analyses and documentation related to the new system, but will not be the basis for deciding on which system to implement. It is a documentation report, not a decision making report. The Policy Paper is the document on which decisions will be made. See also responses to Questions 18, 23, 46, 96 and 101.

72. Question: Page 18. Please elaborate on the potential amendment in the scope of the contract on October 1, 2007. What might be examples of how the scope would change? Would this change in scope also involve a change in total payment to the Contractor (at the hourly rates effective through June 30, 2008)?

Response: The RFP states that, "The scope of the contract will be reviewed and amended effective October 1, 2007, based on the needs of the State during the first year of implementation of the new payment system." This provision was added to provide the State with an opportunity to amend/revise the scope of the project based on the status of system implementation and assistance that might be needed during the implementation

phase, new requirements that may have emerged during the course of the contract, or unforeseen issues that require analysis or resolution. This could result in a change in total payment contract amount, but not a change in the contractor's rates. See also responses to Questions 19, 38, 39, 73, 82, and 100.

73. Question: Page 18. Many states accept personnel billing rates that include base salary, fringe benefits, overhead and margin, with travel and other direct costs then broken out separately. Would this response be acceptable for this proposal? To protect the privacy of our employees, we would prefer not to show less aggregated hourly rates.

Response: Fringe benefits can be identified as a common percentage for all personnel involved in the engagement. Margin and overhead should be separately identified, and should be identified in the aggregate and as a percentage of total costs. Base costs for each person that will be involved in the engagement must be identified. See also responses to Questions 19, 38, 39, 72, 82, and 100.

74. Question: Page 20. Does the State have an appropriation or other budgeted amount for this project? Does the state have an expected level of effort for this project?

Response: The expected costs for this engagement are included in the OVHA budget for the current fiscal year, but there is no specific line item or budgeted amount. The State does not have a predetermined amount allocated to this project.

75. Question: Page 20. Does the State have any preference for how the proposed technical approach is organized?

Response: No, but the bidder should address the requirements included in that section of the RFP (Work Statement, pages 20-24). Proposals that are clear and well organized will be viewed more favorably.

76. Question: Page 26. Please provide more detail on how the proposals will be scored during the Step II review.

Response: Bids will be scored by multiple staff within OVHA. Scores will be combined among evaluators to produce a composite score for each proposal. The State will not comment further on the evaluation methodology beyond the description included in the RFP.

77. Question: Page 26. How will scores be awarded for cost during the Step III review?

Response: Generally total bid cost and the cost per hour/number of hours are considered in the evaluation of the cost proposal. Also see response to question 76.

78. Question: Page 29. Does the state have guidelines on what bidders can label as proprietary material?

Response: The State does not have guidelines on what bidders can label as proprietary material. Bids are subject to FOI requests once a contract has been executed. The State would be unwilling to withhold material inappropriately labeled as proprietary. The State's legal staff could be asked to review material to be released to determine if proprietary material was properly labeled.

79. Question: Page 33. What is the interim payment-to-charge rate (or rates) for outpatient services?

Response: The interim payment-to-charge rate (or rates) for outpatient services is in the range of 30 percent to 45 percent.

80. Question: As a certified public accounting firm, we do not have our financial statements audited. Would internally-prepared financial statements and a bank reference letter meet the requirement in Section II-B of the RFP?

Response: Yes, the State will accept internally prepared financial statements.

81. Question: Will the State provide the budget amount appropriated for this project?

Response: No

82. Question: Should bidders include a cost for implementation assistance services in their cost proposal as an optional service or will those costs be negotiated later?

Response: Bidders should assume implementation services subsequent to October 1, 2007, and should submit their bid accordingly. See also responses to question 19, 38, 39, 72, 73 and 100.

83. Question: Outpatient prospective payment systems such as Medicare's APC system have stringent data requirements. Is Vermont Medicaid currently requiring providers to include HCPC codes for each procedure and then capturing this information in the State's MMIS System?

Response: The MMIS captures and stores the data elements submitted by the providers. There are not data requirements. Some claims analysis will have to be made to determine if the data in the MMIS is sufficient for APC analysis and modeling.

84. Question: Will the rates at the Brattleboro Retreat be part of this project?

Response: Yes, but the specific way in which rates will be affected will be determined based on the work done by the Contractor. However, IMD rate are not the first priority for the contract.

85. Question: To what extent have stakeholders been involved with this project and other objectives been prioritized?

Response: The project has been discussed with VAHHS and they are aware that the RFP has been issued. Traditionally, affected provider groups have been involved in development of significant change in reimbursement, as is reflected in the requirements set out in the RFP. However, Medicaid payments represent a small portion of hospital revenues, so the impact of Medicaid payment changes on hospital behavior is correspondingly not as significant as, for example, Medicare.

86. Question: Are Border Hospitals represented by the VAHHS?

Response: No, but typically Dartmouth Hitchcock Medical Center is invited to participate in the review and discussion of Vermont initiatives and payment changes that will affect DHMC. Vermont has a specific payment class for border teaching hospitals. This class gets a higher reimbursement rate, which is supported by provider tax donations from DHMC. These donations qualify under CMS rules.

87. Question: Are Border hospitals outpatient services cost settled?

Response: Yes

88. Question: Can the State provide a data dictionary for inpatient and outpatient data i.e., what data is available for use by the contractor?

Response: The two primary sources of data are claims and cost report data. Cost report data may not be available for the most current year for all hospitals. Claims data that is captured and stored will be available to the contractor. We are only aware of one field (admission status code) on an inpatient claim that we capture and do not store in our warehouse. A limited number of claims fields are used to adjudicate inpatient and outpatient claims, so some data elements are not edited for accuracy as part of the adjudication process.

89. Question: Do we maintain CPT, Diagnosis and HCPCS and codes in the system?

Response: These codes are captured and maintained in the claims system.

90. Question: Is there any possibility that the claims data will include claims for ineligibles?

Response: Beneficiary eligibility is a required element to pay a claim. If a claim is submitted for an ineligible individual, it will not pay.

91. Question: Is there any difference in the growth rates in the Global Commitment “bloc grant” and reimbursement rates?

Response: There are annual increases in the Global Commitment that the State believes is sufficient to cover increases in reimbursement to providers. The State is not initiating this project to reduce expenditures under the GC.

92. Question: Does “Budget Neutral” as used in the RFP mean system wide?

Response: Yes. However, whether budget neutrality will also have to be maintained at a specific hospital level is unknown at this time. This could be part of negotiations with the Legislature. It could be an issue for a local legislator who in turn could bring it to the Legislature for resolution. It will no doubt be of considerable interest to VAHHS members. See also responses to Questions 2 and 44.

93. Question: Are meetings with legislative committees intended to be for informational purposes only?

Response: Yes, that is the expectation. The early involvement with VAHHS is intended to provide an opportunity for the early identification and resolution of issues so providers will be “on board “to the extent possible during the 2007 Legislative session. It should be noted that there are modest hospital rate increases budgeted to be effective 1.01.07. The requirement that the Policy Paper be prepared by February was designed to assist in addressing legislative questions that may come up during the session concerning the proposed system changes.

94. Question: Given the timing of the Policy Paper, is it the intent that most of the work be done by February, including work with the Hospital Association?

Response: Yes, this is the expectation. The bulk of the work will be done by February. VAHHS has been asked to work with the State to assure that there are not disagreements over any fundamental numbers used in the Contractor’s analysis.

95. Question: What is the time line for reaching agreement on the data?

Response: No time line has yet been set. In our preliminary discussions with VAHHS, we did agree to work together closely on this issue and be sensitive to delay. We have already agreed to use hospital fiscal years. All hospital fiscal years begin 10/1. The most recent year therefore will be HFY ‘05. We do not anticipate significant disagreement on the data.

96. Question: What is the relationship of the two deliverables – February and October? What is the relationships between the February deliverable and the October deliverable.

Response: The Final Policy Paper (October deliverable) will record and reflect policy decisions and analyses made throughout the project. It is expected that decisions essential for an October 1 implementation will have been made sufficiently in advance of October 1 to meet that implementation goal. The February deliverable (Policy Paper) will be a basis for or reflect decision making on system changes to be implemented in October. See also responses to Questions 18, 23, 46, 71 and 101.

97. Question: What is to be bid for the post October 1 period? Is SPA approval required for the change in the methodology?

Response: It is unclear if CMS approval is required, but the proposed changes will be at a minimum shared with CMS. See also response to Question 11.

98. Question: Has EDS provided any input as to the lead time for system changes prior to an October 1 implementation.

Response: The National Provider Identification system must be on line by May 2007. October 1 was selected as a target date for implementation as it will give EDS time to implement the new system between May and October of 2007. This will mean that the Contractor will need to have completed much of the design work between February and May. This is also a rationale for early involvement of VAHHS in the process.

99. Question: Does VAHHS speak for the hospitals as a group?

Response: Generally VAHHS speaks with a single voice, but it is possible that this will not be the case with this project. The hospitals are currently represented by two different lobbying groups.

100. Question: What needs to be in the price proposal subsequent to October 1, 2007?

Response: Also see responses to Questions 19, 38, 39, 72, 73, and 82. The price proposal should:

- A). Identify costs and staff time associated with work completed prior to 10.01.07.
- B). Identify costs and staff time associated with work to be completed after 10.01.07.
- C). Use the same rate for all work proposed until 6.30.08
- D). Include both pre October 2007 and post October 2007 costs in the total for the cost proposal.
- E). Identify margin and overhead. Margin and overhead should be identified in the aggregate and as a percentage of total costs for the entire proposal. It is not necessary to separate out margin and overhead for the pre and post October 2007 periods.

101. Question: Will EDS be prepared to implement a Medicare like outpatient system? Do they currently process Medicare claims based on the Medicare system?

Response: It is possible that the outpatient system will have to have a separate implementation timeline. EDS currently processes Medicare cross over claims based on a tapes provided by CMS. EDS does not assign APCs to any claim. See also responses to Questions 18, 23, 46, 71, and 96.

102. Question: Is the claims file sufficient to support an APC system?

Response: We are not confident that we can answer this question accurately at this time. See answer to question 83.

103. Question: Will the Medicaid audit just announced by the State Auditor of Accounts have an impact on this project

Response: OVHA does not foresee an impact.

104. Question: Are there any other contractors affected by this change, other than EDS, such a TPL, peer review, QM that the contractor will need to be involved with or be aware of?

Response: No

105. Question: Will DSH payments need to be addressed by the Contractor?

Response: No, DSH payments and the DSH methodology will be outside the scope of the contract.

106. Question: Are 10 copies and an original required to be submitted?

Response: No, the State has determined that an Original and five (5) paper copies will be sufficient. In addition, a copy of the entire proposal must still be submitted in an electronic format as required by the RFP.

REQUEST-FOR-PROPOSALS
STATE OF VERMONT
HOSPITAL PAYMENT SYSTEMS CONSULTATION
LETTERS OF INTENT RECEIVED

Treo Solution

EP & P Consulting

Myer and Stauffer, LC

Northfield Associates

Burns and Associates

BD Analytic

Public Consulting Group

Navigant Consulting?

CGI

Mercer Health & Benefits

Milliman, Inc.

ACS

**REQUEST-FOR-PROPOSALS
STATE OF VERMONT**

HOSPITAL PAYMENT SYSTEMS CONSULTATION

BIDDER CONFERENCE ATTENDANCE

Myer and Stauffer, LC

Northfield Associates

EDS

Burns and Associates

Public Consulting Group

CGI

Mercer Health & Benefits

ACS

Health Management Associates

Pacific Health Policy Group

VERMONT TAX CERTIFICATION

**STATE OF VERMONT
Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495-2806**

VERMONT TAX CERTIFICATION

To meet the requirements of Vermont Statute 32 V.S.A., S 3113, the certification shown below must be completed, signed and returned with your bid. This certification is required by law, and without it, the Office of Vermont Health Access is not able to issue your company any purchase order or contract that could result from this bid proposal.

The disclosure of your social security or federal identification number is mandatory, is solicited by the authority granted by 42 U.S.C. S405 (c) (2) (c), and will be used by the Department of Taxes in the administration of Vermont tax laws, to identify individuals affected by such laws.

By law, no agency of the State may enter into, extend or renew any contract for the provision of goods, services or real estate space with any person unless such person first certifies, under the pains and penalties of perjury, that he or she is in good standing with the Department of Taxes. A person is in good standing if no taxes are due, if the liability for any tax that may be due is on appeal, or if the person is in compliance with a payment plan approved by the Commissioner of Taxes. 32 V.S.A. S 3113.

Maximum penalty for perjury is 15 years, a \$10,000 fine, or both.

I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to, or in full compliance with a plan to pay any and all taxes due the State of Vermont as of the date this statement is made.

Name of Company (Print or Type) _____
Date

By (Signature)

Federal Identification Number
or Social Security Number _____
VT Business ID Number
(Indicate if to be applied for)