**Request for Proposals**

**Data Services and Analytics Platform**

February 03, 2014

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Notice to vendors and other interested parties

We invite proposals to provide data aggregation, analysis, and reporting services to the Oregon Health Care Quality Corporation (Q Corp) for the Oregon Healthcare Quality Reporting System (OHQRS). Proposers may respond to some or all of the five separate service requirements outlined in Sections 1-5 of Part V.

Since its first public reporting of health care quality information in 2008, Q Corp has become both a local and national model for translating data from multiple commercial, Medicaid, and Medicare Advantage health plans into objective, actionable information for policymakers, consumers, providers, health plans, employers, and other stakeholders. Q Corp’s core measure set has evolved and expanded year after year, aided by the technical expertise of its multi-stakeholder Measurement and Reporting Committee. Over time, the push for increased transparency in health care has grown, and quality reporting has been included in many local and national initiatives to improve care.

The OHQRS initiative has evolved since its inception, and Q Corp is now using this RFP to re-assess the capabilities of the market to support the evolving strategic direction. Q Corp has eight years of historical claims data, representing care for three million Oregonians since 2006. Data for the 2012 measurement year represents care for nearly two million members. The aggregated dataset allows Q Corp to track care even when patients change health care coverage, providing a more complete view of health care quality and utilization than would be possible with data from a single source.

The data aggregated by Q Corp represents 83 percent of the commercially insured population, 100 percent of the Medicaid population and 91 percent of the Medicare population in Oregon. In December 2013, Q Corp received Medicare Fee For Service Data as the CMS Qualified Entity for Oregon. More information about Q Corp data sources can be found in the 2013 report, *Information for a Healthy Oregon*[[1]](#footnote-1).

Desired Services

Q Corp seeks a vendor to provide the following data services:

1. Acquire healthcare claims and other administrative data from multiple health plans, create a data warehouse infrastructure to manage the data, and provide access to the data to Q Corp and its customers.
2. Acquire clinical data, including but not limited to, data from provider inpatient and ambulatory electronic health records (EHR) and practice management systems, pharmacy, laboratory, vital statistics, and immunization records.
* Integrate and manage clinical data, and merge it with claims information in the data warehouse.
* Create and manage provider and patient registries.
1. Provide a basic standard web-based reporting and analytics platform(s) primarily to support providers in obtaining standardized reports, detailed metrics, and other information about their quality of care.
2. Provide access to the combined clinical and claims data warehouse for the purpose of advanced ad-hoc or custom data analytics and measurement by Q Corp statisticians and analysts.
3. Operate one or more web-based portal services, for health plans, providers, consumers, policy-makers and other stakeholders.

The full text of the RFP may be obtained via the Internet at <http://www.q-corp.org>. Questions regarding the RFP should be directed to Q Corp at the address listed below. Q Corp reserves the right to reject any or all responses or to accept any proposal or portion thereof, if deemed to be in the best interests of the community.

Oregon Health Care Quality Corporation
520 SW Sixth Avenue Suite 830
Portland OR 97204-1514
Fax: (503) 548-4849
Email: karri.benjamin@q-corp.org

# General Background

## Q Corp and Program Overview

The Oregon Health Care Quality Corporation (Q Corp) is an independent, nonprofit organization dedicated to improving the quality and affordability of health care in Oregon by leading community collaborations and producing unbiased information. As a multi-stakeholder organization, a technical committee composed of consumers, employers, providers, policymakers, health insurers, and others guides Q Corp’s measurement and reporting initiative. This initiative has produced Oregon’s most comprehensive system for measuring and reporting the quality, utilization, and costs of health care.

### Q Corp Claims Database

Q Corp currently receives administrative claims data from 15 of Oregon’s largest health plans, the Oregon Health Authority Division of Medical Assistance Programs (Medicaid), and the Centers for Medicare and Medicaid (CMS). This information is used to produce reports for consumers, employers, providers, policymakers, health insurers, and other stakeholders.

Q Corp’s claims database now includes claims data representing care since 2006 for over three million Oregonians. The data includes standardized extracts of Medicare claims data under parts A, B, and D that are available to Medicare Certified Qualified Entities. This data is combined with data from other sources to evaluate the performance of providers, hospitals, health plans, and communities. Q Corp seeks a vendor to house and maintain the data warehouse and expand its scope. (See Table 1 below for additional detail on the current and anticipated data volume estimates.)

### Q Corp Provider Directory

Q Corp maintains a comprehensive primary care provider directory for Oregon. For reporting purposes, this directory links practicing providers with the clinics and medical groups where they work. Q Corp’s provider directory currently has information for 3,394 primary care providers. Q Corp seeks a vendor to maintain and enhance the provider directory to include the full spectrum of all licensed and credentialed healthcare providers, including specialists and hospitals, together with new capabilities to access the directory through a secure web-based provider portal.

### The Opportunity to Integrate Clinical Data

With the widespread adoption of certified electronic health records (EHRs), it is now becoming possible to combine clinical information with claims to obtain more robust information on care utilization, costs, and outcomes. The combining of information from sources such as provider EHR with claims data has been identified as a key strategy by Q Corp.

The successful vendor will assist Q Corp in blending clinical and administrative data from multiple sources to obtain a more complete picture of the care delivered in Oregon and its associated costs. The combined data will permit reporting on outcomes measures in addition to the current process measures, as well as supporting the translation of evidence into practice and informing policy.

To effectively integrate clinical and claims data, Q Corp will require a critical function to crosswalk/match multiple member IDs into a single patient identifier. It will be necessary to do the same for providers, thus establishing the capability to track individual members and physicians across multiple care settings and payers.

### Current Environment

Q Corp provides reporting and metrics services to support a number of key initiatives for local, regional, statewide, and federal stakeholders. These initiatives include the statewide annual report, provider reports, patient experience reports, condition and utilization reports, consumer reports and cost reports. As Q Corp has engaged with its stakeholders and customers and considered new projects, it has become apparent that higher quality, more granular, and more real-time reporting is needed by all stakeholders. For example, in Oregon, the Medicaid waiver and creation of Coordinated Care Organizations (CCOs) necessitate the gathering and analysis of 17 measures, 3 of which are clinical. These measures will be used to determine the quality of care delivered and improvement in outcomes, central tenets to the Medicaid waiver.

Recently, the OHA hosted a series of public meetings that developed recommendations to address the rapidly changing health care environment:

* Reliable, actionable information created from aggregated clinical quality data to support quality reporting and improvement efforts and enhance health plan and CCO abilities around population management, targeting of care coordination resources, and the development of new methodologies to pay for outcomes.
* Statewide clinical quality data registry to collect and aggregate key clinical quality data, develop benchmarks and other quality improvement reporting, collect and calculate CCO clinical incentive metrics, and meet federal requirements for Meaningful Use incentive payments to providers. Health plans and CCOs can leverage state infrastructure to meet reporting requirements to OHA and receive collected clinical data for their members for analytics/quality improvement.
* Technical assistance to providers to help providers meet their Meaningful Use requirements while ensuring that clinical data for metrics captured in EHRs are accurate and complete. Technical assistance can improve credibility of EHR data underlying clinical quality measures, bolstering provider confidence in metrics.

Quality Corp plans to continue to expand its data services to meet the growing need of organizations responsible for the CCO reporting requirements and improving the quality and affordability of care for their members. In addition, there is a need for Q Corp to provide additional custom products that are also rapidly evolving, including health information exchange (HIE), health insurance exchange/marketplace (Cover Oregon), CCOs, private insurance exchanges, and commercial insurance plans, among others. Q Corp’s role in these efforts may vary from stakeholder participation to providing custom solutions and services to the respective organizations to support their data gathering and reporting needs.

Outside of statewide initiatives and activities, there are changes at the national level that Q Corp must consider as it moves forward with changing its data services approach and expansion of reporting and analytics products. Some of these initiatives include:

* Comprehensive Primary Care Initiative
* EHR Meaningful Use Incentive program
* Patient Centered Medical Home
* Accountable Care Organizations
* National efforts to align quality and cost measures
* Implementation of the Affordable Care Act

These initiatives all require some level of data collection, analysis, and reporting. As payment for delivery of health care and outcomes is tied to gathering and reporting specific measures from a wide variety of health care providers and payers, Q Corp must expand its capability to collect data via multiple mechanisms and present the information back to a variety of customers in a meaningful way. Quality data in these arenas is being used for:

* Provider network selection and management
* Payment reform
* Pay-for-performance
* Provider contract incentives
* Clinical improvement
* Development of alternative payment methodologies
* Opportunities to reduce costs and improve care

Q Corp’s vision for the range of data sources, data warehouse services, and analytic capability is described in Figure 1. Current and future sources of information are depicted on the left. The stakeholders and analytic services are shown on the right of the diagram. In the center, the anticipated future Q Corp data warehouse includes not only claims and administrative information, but also clinical and patient experience data from a wide range of sources.

Figure 1. Q Corp's vision for a rich set of healthcare data to be used for quality improvement efforts among all stakeholders in the public and private sector

## Critical Success Factors for Q Corp Partnership with Data Services Vendors

Q Corp’s success in supporting providers, health plans, CCOs, consumers, policy makers, purchasers, and other stakeholders in measuring and improving the quality and affordability of health care for Oregonians is critically dependent on the exemplary support and services from its Data Services Vendor(s). This is especially the case as Q Corp addresses the expanding needs of stakeholders that are transforming health care services in Oregon. As such, the critical success factors for the Data Services Vendor relationship are:

* Commitment to the mission and vision of Q Corp that results in products and services that significantly improve in the quality and affordability of healthcare for all Oregonians.
* Fully supports and complements Q Corp’s reputation as a leader in Oregon’s quality and cost measurement, monitoring, analytics, and improvements efforts.
* Actively supports and facilitates the development of new ad hoc reports and products and real-time reporting tools to meet evolving needs as opposed to canned reports based on static data structures.
* Commitment to a flexible partnership for developing innovative new services and products.
* Flexibility to support the multiple initiatives and customers Q Corp currently supports and plans to support.
* Continuous work to improve the timeliness, accuracy, and value of data and metrics as well as the access and availability to Q Corp and stakeholders.
* Provision of timely and ready accessibility to detailed data by Q Corp staff for analysis, data validation and verification, and process monitoring.

## RFP Overview and Rationale

Q Corp is issuing this RFP and intends to select one or more Data Services Vendors and establish contracts based on the evaluation of bidder responses. “Data Services Vendor” means the independent contractor under contract to Q Corp to provide contracted data acquisition, management, and analysis services to support OHQRS.

Q Corp is expanding its capability to collect, analyze, and display data via multiple mechanisms. Q Corp customers and stakeholders depend on this aggregated information for a variety of uses, including provider network selection and management, pay-for-performance monitoring and adjudication, provider contracting, clinical quality improvement, development of alternative payment methodologies, and identifying opportunities to reduce costs and improve care.

The revision to HIPAA under HITECH Act (2009) requires Q Corp to update the legal framework governing its data suppliers and the Data Services Vendor. Q Corp will require the vendor to expand access to protected health information (PHI) as described in Section VI, Privacy and Security. (Q Corp access to PHI was not included in the original data services RFP and framework.)

Q Corp is revising its participation agreements with medical groups and other data suppliers. The expected capabilities to access patient detail in a timely manner will help Q Corp to ensure the accuracy and validity of metrics and reports, assist with identifying and addressing data quality issues, and provide a means for expanded analyses and greater accountability and responsiveness to stakeholder interests and requests.

For the purpose of this RFP, Q Corp will assume the majority of analytic capacity and staffing; vendors will provide the platform, tools, and solution support to allow Q Corp to maintain leadership in the region as a provider of health care analysis and intelligence. Q Corp seeks to implement solutions that support standard metrics targeted to consumers, providers, health plans, government, and others, as well as powerful and ad hoc analytics and statistical capabilities.

## Measures of Quality

Q Corp delivers quality, utilization and cost measures through a variety of formats and mechanisms. Reports derived from aggregated data are offered through websites—both privately to providers and in publicly accessible initiatives. We provide public reporting of quality metrics, providing Oregonians with information they can use to help them get quality health care. Reports appear at <http://www.partnerforqualitycare.org/>. We create provider reports that are available for primary care providers, medical group administrators, and clinic managers. Online quality measurement reports and patient-level data are housed on a separate, secure website.

In addition, Q Corp authors commissioned reports to summarize the quality of care being provided annually for a statewide audience in Oregon.

The current list of baseline provider measures is provided in Appendix A. Additional measures will become part of the baseline set as the requirements of Q Corp’s stakeholders evolve. Q Corp is responding to the need for quality measures used under a number of state, federal, and private sector programs including:

1. HITECH Meaningful Use Stage 2 (<http://www.healthit.gov/policy-researchers-implementers/meaningful-use-regulations>)
2. Cover Oregon health insurance exchange (<https://www.coveroregon.com/>)
3. Oregon CCO Measures (<http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx> > Technical Specifications)
4. Oregon Patient Centered Primary Care Home Program (<http://www.oregon.gov/oha/ohpr/Pages/healthreform/pcpch/index.aspx>)
5. Other Community Quality Improvement initiatives such as the Oregon Perinatal Collaborative

## Base Reporting and Analytics

In the context of this RFP, “base reporting and analytics” refers to standardized, filtered and parameterized reports that will be run by Q Corp and its stakeholders on a routine basis. These will be presented in a user-friendly, web-based presentation layer. In this type of reporting, Q Corp requires relatively basic data manipulation such as filtering, ordering, selecting parameters, and exporting both aggregate and patient-level data presented from the web interface.

The content of the base reporting system will include:

* NQF-endorsed standard measures
* Variations on NQF endorsed measures
* Custom measures

Q Corp’s base measures are established by consultation with the Measurement and Reporting (M&R) team and are modified on an annual basis. The proposed solution must support ongoing accreditation (see below) and modifications of measures over time.

The expected solution would be a web interface for a business intelligence tool. Q Corp expects the ability to administer and create measures and dimensions to extend the capabilities of the reporting solution.

The expected users of the based reporting and analytics functions are Q Corp business analysts, physician practices, hospitals, state of Oregon business analysts, health plan and CCO business analysts, and other users with moderate technical fluency.

The base reports must be accessible at not only predetermined intervals for public and private reporting and submission to the State/CMS, but also frequently updated as an ongoing management resource for the expected users listed above.

Q Corp requires that nationally recognized measures used in the base reporting services be accredited by NCQA, URAC, or other accrediting body. The vendor must manage the costs and ongoing maintenance of accreditation. In other words, the vendor must incur costs for accreditations as part of base business operations. Accreditation costs should NOT be passed on directly to Q Corp. In addition, the vendor will support non-endorsed measures and multiple versions of similar measures.

Appendix A contains reference list of base reporting measures.

## Advanced and Ad Hoc Analytics

Q Corp currently uses a variety of tools for statistical analysis and data visualization. Q Corp has made a moderate investment in SAS, which is widely viewed as an industry standard. Although in the recent past our analysts have had the flexibility to work with their tools of choice, Q Corp sees a benefit in moving toward a standardized ad-hoc and statistical analytics platform that is well matched to the respondent's capabilities and solutions. Please make recommendations and propose a standard approach to the use of statistical tool sets and data visualization software.

In the past year Q Corp has produced numerous public and custom reports based on ad-hoc analyses (<http://www.q-corp.org/reports>).

* Hospital readmissions
* Imaging studies
* Low back pain (LBP) reports (<http://www.q-corp.org/reports/statewide-reports>).

### Definitions

For the purposes of this RFP, ad-hoc analysis consists of:

* Filtering and downloading large data sets that will then be statistically analyzed.
* Public health or bio-statistical analysis of healthcare data, parametric and non-parametric tests, visualizing and quantifying differences between subgroups and populations, linear regression, time series, measuring sample sizes and power, reliability etc.
* Non-routine data exploration using visualization tools, based on an analyst’s intuition or business objectives. These types of analyses may have the ability to identify major savings opportunities or gaps in care for local systems, providers, or statewide.
* A custom report or study for a client, for example, CCO measure validation.

## Data Sources and Management Systems

The range of data sources to be acquired and managed in the data warehouse is shown in Figure 2. This figure shows the current and future movement of *patient-level* data. In Figure 2, items shown in **red** indicate the existing set of data functions related to claims. The evolving needs include the items shown in **black**. See Figure 1 for additional details.

The successful vendor will support the main types of data shown, to include the following:

1. Administrative claims
* Claims and utilization data from health plans, the Oregon Health Authority, and CMS (Appendix B).
* In addition to financial and billing data, this information source increasingly includes clinical process flags and other important information for quality measurement.
1. Clinical information
* Provider Ambulatory EHR and practice management systems.
* Hospital/Health System EHR and billing data.



Figure 2. Conceptual architecture reflecting the intended data sources, submission, management, and analytics services provided by Q Corp.

1. Government sources such as vital statistics and state immunization registry data.
2. Provider-abstracted quality metric numerators and denominators.
3. Provider feedback and discrepancy reports (taken via the Q Corp web portal).

The desired solution will also accommodate other sources of individual and *aggregated data*, including patient experience survey results and other quality or performance metrics.

## Anticipated Volumes

*Claims Data:* Q Corp seeks a vendor that can rapidly scale the data acquisition and aggregation systems, databases, hardware, networks, web services, and applications to meet growing needs. Table 1 provides an estimate of the current and anticipated volumes that will be supported for the claims and related administrative data.

Table 1 Q Corp Data Volume Estimates

| Service Type | Current a  | Anticipated  |
| --- | --- | --- |
| Claims and administrative data volume (TB) | 9.5 | 12-15 |
| Number of Data Suppliers | 11 | 15-20 d  |
| Number of unique patients | 3,140,730 | 5-6 million c  |
| Number of enrolled patients | 1,930,927 | 3 - 4.5 million d  |
| Number of unique providers b  | N/A | 100,000 |
| Total medical claim records submitted | 348.1 million | 550-650 million |
| Total pharmacy claim records submitted | 153.6 million | 250-300 million |
| Data submission frequency (claims) | Every 6 months | Quarterly potentially monthly |
| Web portal max page views per month | 160k | 200-300k |

a2005 to 2013 cumulative, including Medicare fee-for-service

bPhysicians, Pas, NPs, CRNAs, CNS, Dentists

c All 3.8 million Oregonians plus others that obtain care in Oregon

d Anticipating an increase in the proportion of enrolled patients and participating data suppliers

Additionally, projects under development for implementation in 2014 and 2015 related to total cost of care measures and pricing transparency initiatives will likely include utilization of the Oregon All Payer Claims Database (APCD) that includes claims and related data for nearly all Oregonians enrolled in commercial health plans, self-insured plans, Medicaid, and Medicare Advantage plans. ACPD data would probably represent a single data source/feed that would include 1.25 to 1.50 times the data shown in the anticipated column.

*Maternity Project Data:* The Oregon Perinatal Collaborative is in the process of developing a quality measurement and improvement system related to perinatal care. Data to support the system would include vital statistics data from birth certificates and hospital uniform billing (UB) data generated by participating hospitals directly or through the Oregon Association of Hospitals and Health systems under arrangements that are still being worked out. For planning purposes, the OHQRS needs the capability and capacity to accommodate hospital UB data for mothers and babies for approximately 45,000 deliveries per year and potentially an additional 300,000 in-patient discharges for non-maternity cases. The hospital UB data not only includes standard billing information and coding but also contains an extended set of diagnoses and procedure codes. The maternity-related data is likely to be exported to another data center that operates a specialized maternity quality measurement system.

*Clinical Data:* Clinically oriented data will begin to be added into the OHQRS system starting in 2014 in various data formats and submission methods. The amount of submitted information will increase over time. The anticipated volume of clinical data is difficult to estimate but over time is expected to include information related to clinically oriented measures/metrics for approximately 5 million patients.

# Proposal Requirements

## RFP Focus and Goals

As a fundamental principle of this RFP, Q Corp intends to purchase a core service for data aggregation, data analysis, web-based reporting, and provider feedback from a vendor who can demonstrate previous success implementing existing solutions for similar organizations. The successful bidder(s) will have in place demonstrable solutions (not including projects in the process of implementation or in development) that:

* Aggregate, consolidate, and validate claims and administrative data from various health plans, and combine related data and information about patients, providers, services and other care delivery characteristics, for the purpose of developing quality measurement data and other results based on national and local measurement standards.
* Aggregate, consolidate, and validate patient clinical data from provider EHR systems and other sources, and combine related data and information about providers, services, and other care delivery characteristics for the purpose of developing quality measurement data and other results based on national measurement standards.
* Combine and validate administrative and claims data with clinical data, plus related data and information about patients, providers, services, and other care delivery characteristics for the purpose of developing quality measurement data and other results based on national and local measurement standards.
* Develop community provider directories and methods to attribute patients to physicians, clinics, and hospitals and offer multiple options or algorithms for achieving this capability. Structure the directory according to ONC recommendations.
* Create and report quality and performance measures at the practice and clinician level, including local and national standard measures, based on integrated claims and clinical information from sources (1), (2), and (3) described above. The reports will employ both local and nationally standardized quality measures endorsed by NCQA, AQA, and NQF according to current specifications and must be regularly updated as new standards are adopted. The vendor will maintain certification from nationally established quality organizations for the duration of the contract.

The ideal bidder will also demonstrate solutions that:

* Collect EHR data for clinical quality measures from providers in HL7 QRDA-compatible format, using an automated, web-based solution, to include:
* Aggregate numerators, denominators, exceptions, and exclusions
* Individual-level quality measure data
* Provide secure systems (meeting criteria set out by the Medicare QE program, including staff-level security) that enable clinics to download patient-level data and submit appeals to correct data
* Offer interactive web services for participating health plans and provider organizations to review OHQRS data
* Generate OHQRS performance reports that can be integrated into the OHQRS public reporting system of quality measures and consumer engagement strategies

The successful vendor will provide dedicated management staff and systems that consistently produce high-quality results on time and budget. Q Corp requires a partner with the commitment to timely and accurate project planning and communications about solution delivery progress

The Vendor Cost Proposal (Section IX) must include both a base price for the expected scope of services described, as well as an incremental cost or cost parameters that would allow solution expansions (e.g., cost per additional health plan, additional conditions, or measures). Q Corp intends to select the proposal(s) that provides the best overall technical and financial value, then to negotiate final terms with the selected vendor(s). Ideally Q Corp intends to contract with one vendor for the full scope of services, but reserves the right to contract with multiple vendors.

## Detailed Timeline and Response Instructions

Q Corp anticipates the following approximate timeline for the RFP, responses, vendor evaluation and selection, and contract finalization.

Table 2 RFP Timeline

| Date | Action |
| --- | --- |
| 3-Feb-14 | Issue RFP  |
| 10-Feb-14 | Vendor conference, written questions due |
| 14-Feb-14 | Initial FAQ/answers to vendor questions posted to Q Corp website |
| 17-Feb-14 | Letter of Intent due |
| 14-Mar-14 | Vendor responses due |
| 01-April-14 | Presentations from invited vendors on April 1st, 2nd, 3rd  |
| 22-Apr-14 | Vendor notification of intent to award |
| Early June 2014 | Contract negotiations, Scope of Work, Project Plan complete |
| Late June 2014 | Contract executed |
| July-August 2014 |  Implementation and testing |
| September 2014 | Comparative results replication and validation |
| December 31, 2014 | Complete transition to new vendor |

It is the intent of this proposal to identify one or more Data Services Vendors to support the OHQRS. Q Corp intends to implement services that cover the entirety of Part V below.

A vendor and/or a vendor partnership may respond to all sections with a single proposal. For example, a data warehouse vendor could submit a proposal that covers only Part V, Sections 1 and 2. A vendor specializing in analytics may submit a proposal that covers only Part V, Section 3; Part V, Section 4; or both. A vendor that specializes in portal development could respond only to Part V, Section 5.

If multiple vendor proposals for different parts are accepted, all vendors will be required to work together under Q Corp direction and management.

If your response consists of a collective or partnership of vendors, you must designate a prime contractor. Also, indicate your willingness to consider partnering with other Q Corp vendors to provide components of the services. Q Corp will retain the right to select different vendors for the functional solutions desired in Sections 1-5 of Part V.

## Submitting Your Response

Submitting your response includes submitting a Letter of Intent to Bid as well as a complete proposal.

### Submitting Your Letter of Intent

Complete and electronically submit a letter indicating your Intent to Bid to Q Corp at the following address:

Email: karri.benjamin@q-corp.org

The letter of intent must include the following elements:

1. Indicate which of the five components of the RFP that are expected to be included in your proposal:

| Component | Yes | No |
| --- | --- | --- |
| Claims data acquisition and processing |  |  |
| Clinical data acquisition and processing |  |  |
| Basis standard reporting and analytics |  |  |
| Advanced data analytics and measurement |  |  |
| Web-portal services  |  |  |

1. Identifying and contact information for the organization and key account representative(s).

3. Compete the following table by providing the number of lives, claims, and data feeds involved in providing services to your top four clients who are similar to Q Corp.

|  |  |  |  |
| --- | --- | --- | --- |
| Client for Claims Data | Average lives per month | Average claims per month | Number of data feeds |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |

### Submitting Your RFP Response

The following Parts are *required* from vendors responding to any part of the RFP:

Part IV: RFP Attachments

Part V: Response Detail

Part VI though IX

Use the following outline to prepare your response:

1. Executive Summary
2. Experience Summary
3. Detailed Response to Section V Response Detail
4. Detailed Response to Section VI Privacy and Security Protections
5. Detailed Response to Section VII Contractual Issues
6. Detailed Response to Section VII Project Management, Services, and Support
7. Response to Section IX Financial. Include pricing table and payment schedule using the provided spreadsheets
8. Attachments specified in Section IV Respondent RFP Attachments

The Bidder shall provide 1 original unbound proposal and 5 paper copies of the response. The unbound proposal shall be marked "Original" and will contain original signatures for Certification and Assurances (Appendix E). The remaining 5 copies do not require original signatures. An electronic media version of the response shall be saved in one single document in PDF format, including all attachments and spreadsheets. Vendors will also deliver electronic responses securely via a file sharing service; additional instructions for electronic delivery will be provided in the vendor FAQ.

Proposals should be delivered either in person or via US postal service or other approved delivery service in a sealed package (box or envelope), which is conspicuously labeled "SEALED PROPOSAL – OREGON HEALTH CARE QUALITY REPORTING SYSTEM." The package should also contain the name, address, and telephone number of the proposing firm.

Proposals should be addressed to:

Oregon Health Care Quality Corporation
520 SW Sixth Avenue Suite 830
Portland OR 97204-1514
Fax: (503) 548-4849
Email: karri.benjamin@q-corp.org

All RFP responses must be received by 4:00 p.m., Pacific Standard Time, March 14, 2014.

Q Corp will not be responsible for any expenses incurred by the Bidder in preparing and submitting a proposal. Proposals should be prepared simply and economically, providing a straightforward, concise description of the Bidder's offer to meet the requirements of the RFP. Successful proposals will succinctly document relevant experience and proposed approaches in plain English and avoid marketing hyperbole.

## Notifications

Q Corp reserves the right to:

* Reject any or all applications submitted.
* Request additional information from any or all respondents.
* Conduct discussions with respondents for the purpose of clarification to assure full understanding of, and responsiveness to, the solicitation requirements.
* Approve or reject subcontractors proposed or used in carrying out the Scope of Services.
* Revise and amend the RFP.
* Negotiate the Scope of Work.
* Contract with multiple vendors.

# Minimum Vendor Qualifications

Eligible vendors will have demonstrated experience in providing solutions to aggregate claims data from multiple health plans, or for organizations affiliated with NHRI, AF4Q, APAC, Medicare Certified Qualified Entities, or statewide Medicaid databases. To be eligible, vendors must also have either: a) demonstrated experience aggregating clinical data from multiple sources, or b) provide a suitably detailed plan for incorporating for clinical data with existing claims information as part of this RFP response.

#  Respondent RFP attachments

Q Corp requires all vendors to submit the following information in Section IV to assess the ability of a responding vendor to capably handle the tasks required by the RFP. Label each section as listed below.

## Company Description

Provide a brief history of the firm, including the type of business structure, an annotated client list, and a description of its full book of business, including the types of services provided for each client and the years that the services were provided. Identify the number of employees with the firm and each team member, title, and FTE allocation expected to work on this contract.

In addition, provide:

* An organization chart showing the parent company and relevant subsidiaries.
* An organization chart illustrating major departments and areas of the organization, by function. Include the names and titles of senior management.
* An organization chart for the Q Corp account team. Include subcontractors.
* Key contracting firms or solutions providers that will be used. List all additional contracting firms or solution providers that you expect to contract with for this project. Indicate the product, service provided, or role filled by each subcontracting organization.

## Company Financial and Legal Status

Summarize financial information for the company for the past two completed fiscal years. Include any mergers and acquisitions undertaken during the last two years and detail any proposed mergers that may affect the financial stability or organizational structure of the organization*.*

Include evidence that your company has carrier and liability coverage for errors and omissions, including data breaches, in effect for the duration of this contract. You may scan and attach the insurance summary here.

Summarize the status of any actual and threatened litigation and regulatory agency actions taken involving the company since 2009 (include both pending and closed).

## Account Management Team

Submit a biography or resume for each member of the company who is expected to interact directly with Q Corp on this engagement. Include name, title, work to be performed for this contract, and geographic location.

## Project Management Approach

Describe your approach to project management and your organization’s track record for producing contract deliverables according to specifications and budget.

## Problem Projects

Describe any projects that have run into problems in the past three years. List de-installed solutions or service transitions to another vendor involving customers similar to Q Corp. Why did the project encounter difficulties? What will be done to mitigate similar risks encountered in the proposed project?

## Relationship and Communications Management

Describe your approach to relationship and communication management with the community partners and stakeholders. How will you assist Q Corp in coordinating with the community? Provide examples of how you have dealt with communications and management issues in the past.

## Respondent References

### Client References

Insert three client references for projects with similar scope—public sector and non-profit collaborative entities are preferred. For each, include the name of the client, the address, the contact person, his/her telephone number, email address, and the nature and scope of the product provided (preferably similar services to those requested in this RFP).

1. What are the 5 most common things that your clients would say differentiate you from your competitors?
2. What is the most common reason a client cites for dissatisfaction with your firm or product?
3. Discuss major achievements and identify projects your firm has completed within the past 36 months that provide experience relevant to this project.
4. Do you have an active user group?

Using the tables below, provide the names and contact information for three clients similar to Q Corp who are currently using your products and services, three who have recently quit using your firm’s services, and three for whom you have recently implemented projects.

Table 3 Current client references

|  |  |  |  |
| --- | --- | --- | --- |
|  | Current Client 1 | Current Client 2 | Current Client 3 |
| Organization name |  |  |  |
| Contact name |  |  |  |
| Contact telephone number |  |  |  |
| Contact e-mail |  |  |  |
| Business model |  |  |  |
| Number of covered lives in hosted data set |  |  |  |
| Name of analytic software provided |  |  |  |
| Analytic services provided |  |  |  |

Table 4 Former client references

|  | Former Client 1 | Former Client 2 | Former Client 3 |
| --- | --- | --- | --- |
| Organization name |  |  |  |
| Contact name |  |  |  |
| Contact telephone number |  |  |  |
| Contact e-mail |  |  |  |
| Business model |  |  |  |
| Number of covered lives in hosted data set |  |  |  |
| Name of analytic software provided |  |  |  |
| Reason for leaving |  |  |  |

Table 5 Projects implemented within the past 12 months

|  |  |  |  |
| --- | --- | --- | --- |
|  | Client 1 | Client 2 | Client 3 |
| Organization name |  |  |  |
| Contact name |  |  |  |
| Contact telephone number |  |  |  |
| Contact e-mail |  |  |  |
| Business model |  |  |  |
| Number of covered lives in hosted data set |  |  |  |
| Name of analytic software provided |  |  |  |
| Analytic services provided |  |  |  |

### Professional References

Insert three professional references with contact information for the proposed Q Corp account manager.

## Proposal caveats

List all exceptions and caveat to the proposal, citing each RFP section to which the caveat refers. These caveats will not necessarily be agreed to by Q Corp.

## Certification and Assurances

Attach a signed copy of the certification and assurances page provided in Appendix E of the request for proposals.

# Response Detail

The Experience Summary is required for all firms submitting a response to the RFP. For the remaining sections, provide detailed responses to the questions for the portions of the project for which you are submitting your proposal.

## Experience Summary

Use this section to document your relevant experience in completing project similar to this one. For brevity, include a single brief description here of each project you reference as you answer questions in this section of the RFP. It may be helpful to return to this question after completing the remainder of the RFP.

Complete the Summary of Related Projects table below, with the following information for three or more customers in the last five years. Add rows as necessary.

* Project/customer: Provide the name and location of the initiative or customer.
* Type, scope, and count of data suppliers: List the number of health plans and/or healthcare provider enterprises who submitted data.
* Frequency of data submission: List the frequency (monthly, quarterly, or other period) with which suppliers submit data.
* Count (lives or patients): List the number of unique records of subjects in the database.

Table 6 Summaries of Related Claims and Clinical Data Services Projects

| Project Number | Project/Customer | Count of Data Suppliers  | Frequency of Data Submission  | Count (Lives or Patients) |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

## Project Descriptions

In this section of the response, provide descriptions of the projects referenced in Table 6. Be sure to include the following information for each project:

* Client name and description
* Date(s) of work
* Project description
* Timeline for key implementation steps
* Your specific role and the role(s) of partners with whom you worked on the project
* Successes and lessons learned

Highlight any similarities with Q Corp’s anticipated project and any work you have done with public entities or public-private collaborations. Use the following questions to focus your project descriptions.

* What data, analytic tools, and services did you provide? Describe the overall solution that you implemented for the project, along with any plans for immediate improvements.
* How long did it take to have your solution in full operation for your customer? What is a typical implementation schedule, based on the range and types of data and information depicted in Figures 1 and 2 of the RFP? How do you commit to timely deliverables? (You may refer to your version of a sample work plan as demonstrated in Appendix C of the RFP.)
* What was the process, cost and timeline associated with adding any new data sources, data types, quality measures, reporting capabilities, and data customers outside the initial RFP scope
* What is your relevant experience deploying the quality measures defined in Appendix A of the RFP?
* Describe how you stay abreast of State and Federal regulatory issues, standards, and technology environment updates, for example Meaningful Use Stage III and beyond?
* Provide a summary of your quality-control plans and processes, including any ISO certification for (a) implementation and (b) ongoing production and operations.

## Detailed Responses

In this section, provide detailed responses to the questions about your previous experience and proposed solutions for each area for which you are proposing to provide services.

1. Data Aggregation Capabilities and Methods

In this section, explain how you will manage data aggregation from multiple sources. Sources include health plan/CMS claims, health plan/CMS preventive and screening services, Oregon Health Authority claims, provider EHR, provider-abstracted information, pharmacy (including e-prescribing), laboratory, vital statistics, and immunizations. Keep in mind the multiple sources you will need to work with as you respond to these questions.

1. Acquisition and Management of Payer Claims and Billing Data

Relevant experience

1. Provide examples of your experience standardizing and integrating data from multiple sources.
2. What processes and tools have you used to develop data specifications and data submission processes for public and private sector entities, including commercial health plans, Medicaid, and provider sources of clinical data?
3. Describe your experience working with price transparency data from commercial and Medicaid data sources, including acquisition, storage, maintenance, and reporting of the following:
4. The coded/ grouped episode of treatment for the individual patient
5. The billed cost
6. The allowable cost
7. Assignment of relative value units (RVUs) and other resource/value metrics
8. Describe any existing expertise with Oregon claims or clinical data.
9. Describe your expertise working with cost and pricing information submitted by health plans for platinum/gold/silver/bronze ACA offerings—such as that provided by the Oregon Insurance Commission (DCBS) price transparency and data center.
10. Experience with CMS, health plan, and other sources of clinical quality and performance information, for example screenings and evaluations performed, based on HCPCS/CPT code sets in claims data.
11. What experience have you had analyzing Medicare Part B Preventive and Screening Services[[2]](#footnote-2) performed?
12. How does your solution report on Commercial Health Plan Preventive and Screening Services performed?
13. Migration of data from the existing OHQRS Data Warehouse. Q Corp desires an efficient and comprehensive plan for migrating approximately 9 TB of patient-level claims and other information from the current data warehouse to the new environment. Provide an example of how you have managed data migration from established multi-payer data sources to your solution platform.
14. How did you approach coordination and communication with the existing vendor?
15. What resources were required from the existing vendor and from the customer?
16. What methodologies and tools were used to move the data?
17. How did you reconcile the previous data model with your own?
18. Was there any data that could not be migrated and staged, if so why, and what was the impact to the customer’s ability to report and analyze information?
19. How long did it take to conduct the entire migration process until the data was accessible for reporting and analysis?
20. Experience with health plan and other sources of claims, billing, and utilization information.

Describe specific and relevant claims-based data integration issues you have faced and explain how you have resolved them. Which specific issues do you think will be the most troublesome?

Proposed Solution

1. How will you integrate data from at least 15 health plans, Medicaid, and Medicare?
2. What challenges do you foresee with integrating large amounts of data from different and varied sources? What steps will you perform, and how will you make it work in a timely and consistent fashion?
3. What is your average performance level in meeting processing deadlines?
4. Data Formats

Relevant experience

1. Provide a list of the available file formats, message standards, or structured document types you have used to package and export data from suppliers. Identify any issues with receiving data in APAC (Appendix B), HL7 QRDA I/III, and HL7 C-CDA. Distinguish between claims and clinical data.
2. Acquisition interfaces and data transport
3. Describe the transport mechanism (for example, web service, batch files, secure FTP, etc.) that you propose to use for this project.
4. At what frequency will suppliers submit their data? (Data must be submitted at least quarterly; monthly is preferred.)
5. Support for Direct Messaging
6. How will your solution support direct messaging to enable you to receive data from MU2-certified EHRs?
7. Describe how your proposed solution conforms to the Direct Project’s Applicability Statement for Secure Health Transport v1.1 ([http://wiki.directproject.org/file/view/Applicability+Statement+for+Secure+Health+Transport+v1.1.pdf](http://wiki.directproject.org/file/view/Applicability%2BStatement%2Bfor%2BSecure%2BHealth%2BTransport%2Bv1.1.pdf)).
8. Describe how your proposed solution conforms to the Direct Project’s Implementation Guide for Delivery Notification in Direct v1.0 ([http://wiki.directproject.org/file/view/Implementation+Guide+for+Delivery+Notification+in+Direct+v1.0.pdf](http://wiki.directproject.org/file/view/Implementation%2BGuide%2Bfor%2BDelivery%2BNotification%2Bin%2BDirect%2Bv1.0.pdf)).
9. Are you currently certified by the Direct Trust Agent Accreditation (DTAAP)/Electronic Healthcare Network Accreditation Commission (EHNAC)? If not, how do you plan to get certified?
10. Data Validation, Transformation and Coding

Relevant experience

1. Describe your experience cleaning and editing raw data feeds to ensure consistency and accuracy.

Proposed Solution

1. What processes will you use to clean and edit raw data feeds to ensure consistency and accuracy?
2. Describe the quality assurance and testing processes you will use to test incoming data feeds.
3. How will you provide feedback to clients and data vendors about data quality?
4. How will you ensure that data is fully and precisely coded?
5. Provider Directory
6. Describe how your solution will perform clinical or administrative assignment of a patient to a provider.
7. Describe how your solution will support creating and managing the provider directory. Address the following:
* Initial load of the directory from a master file or existing database.
* Support for providers to upload provider lists, for example via spreadsheets or manual entry/updates through a web portal interface.
* Allow providers and practices to add the CareAccord or other Direct Secure Messaging addresses into the directory.
* Describe your plans for conformance with the IHE technical framework for Healthcare Provider Directory (HPD) CP601, and the HPD Plus v1.1 relational model <http://wiki.ihe.net/index.php?title=Healthcare_Provider_Directory>, <http://www.ihe.net/uploadedFiles/Documents/ITI/IHE_ITI_Suppl_HPD.pdf> , <http://exchange-specifications.wikispaces.com/search/view/HPDplus>.
1. How will your solution determine the primary provider for a patient?
2. How will your solution handle information coming from multiple providers who are involved in a patient’s care?
3. Describe how your solution will create and store information for a patient’s “care team.” How will the quality measures and metrics be assigned to that care team? How will patient care be attributed to a specific care provider?
4. Explain how the provider directory will manage various types of providers, including:
* Primary care physicians
* Specialty care physicians
* Physician assistants and nurse practitioners
* Dental and vision providers
* Midwives, chiropractors, naturopaths
* Physical therapy and rehabilitation
* Mental and behavioral health
* Hospitals
* Other facilities
1. How will the provider directory handle standard information from licensing boards for the provider types listed above?
2. How will your solution determine the relative importance of the primary provider attributed on a claim versus in the clinical record?
3. What information and support do you expect from stakeholder partners to assist in building the provider directory?
4. How will your solution make the provider directory available to authorized entities? For example, how would you implement a secure web portal for this data?
5. Patient Matching

Your solution must allow aggregation of diverse sources of data for a single patient. *http://q-corp.org/sites/qcorp/files/Information%20for%20a%20Healthy%20Oregon%20-Technical%20Appendix%202013.pdf* provides additional information and a potential methodology.

* Can the system duplicate the method described in *InformationforaHealthyOregon-TechnicalAppendix2013.pdf* ?
* Document the rate of accuracy and the processes used to review and resolve mismatches.
1. How will your solution combine clinical and claims information from different sources for a single patient?
2. How will your solution determine that charts and data from different providers should be attributed to the same patient?
3. How will your solution determine that claims from different health plans should be attributed to the same patient?
4. How will you aggregate all historical claims, enrollment, and medication data, for all encounters for a patient, for the entire duration of the data available since 2006?
5. What is your approach to establishing and using a Master Person Index or registry? Based on your experience, what limitations and challenges do you foresee with this approach?
6. What do you expect your rate of accuracy to be for matching patient data? What processes will you use to review and resolve mismatches?
7. Provider Matching
8. How will your solution combine clinical and claims information from different sources for a single provider?
9. How will your solution determine that charts from different locations are authored by the same provider?
10. How will your solution determine that claims from different health plans are associated with the same provider?
11. What is your approach to establishing and using a Master Provider Index or registry? Based on your experience, what limitations and challenges do you foresee with this approach?
12. What do you expect your rate of accuracy to be for matching provider data? What processes will you use to review and resolve mismatches?
13. Provider Attribution

The system must assign patients to a responsible provider or providers.

* Describe the basic method and algorithms used.
* Can the system duplicate the method described on page 12 of *InformationforaHealthyOregon-TechnicalAppendix2013.pdf* ?
* Document the rate of accuracy and the processes used to review and resolve mismatches.
1. What patient-provider attribution algorithm or algorithms will be deployed in your solution?
2. How will you assess and assure the accuracy of the algorithm?
3. How will you recommend that variations/corrections be applied?
4. Are the algorithms transparent? If your methodologies are proprietary, please describe them in some detail.
5. What do you expect your rate of accuracy to be for correctly assigning a patient to a responsible provider or providers? What processes will you use to review and resolve mismatches?
6. Staging and Data Presentation
7. What process steps will you take to render the data suitable for analysis and calculation of clinical quality metrics?
8. What subsystems will you have in place to perform data staging and presentation?
9. How long after it is submitted will it take you to have clean data available for use?
10. Describe your approach to integrating new data types of elements into an existing data schema. What impact will new requirements have on time to load?
11. How will your solution ensure that the most correct and suitable data source is made available to generate quality metrics during a specific time frame?
12. How will your solution manage duplicate data feeds of the same or overlapping information from different sources? Use the following two examples to illustrate your answer:
* Medicaid data flows from the State and then to Q Corp, while a parallel stream of the same data flows directly from the originating health plans to Q Corp.
* Data feeds of both clinical and claims data for the same patient arrive from both provider and payer sources.
1. Acquisition and Management of New Clinical Data Sources from Electronic Health Records

Relevant Experience

Describe your **e**xperience aggregating and managing detailed patient-level inpatient and ambulatory data, including Inpatient EHR and UB, Emergency Department, Ambulatory EHR, and Ambulatory Procedures.

1. How have you managed the content, structure, and coding of clinical information obtained from diverse provider EHR systems?
2. What processes and solutions have you developed to manage structure, coding, reporting and analysis for clinical EHR data with reference to data elements required by Meaningful Use?
3. How has clinical EHR information been applied to quality measurement based on NCQA and NQF-endorsed measures?

Proposed Solutions

1. Provider Electronic Health Records (EHR)
2. Ambulatory EHR
3. How will the proposed solution support ambulatory electronic health record data, including:
* Patient demographics
* Encounter, visit, document types
* Insurance and insurance type at the visit level
* Provider demographics for the visit
* Problems
* Medications and prescriptions; reconciled medication lists
* Laboratory results
* Vital signs
* Clinical observations
* Allergies
* Orders
* Personal, social, family history
* Past medical history, surgeries, admissions, resolved problems
* Referrals
1. Inpatient EHR
2. How will the proposed solution handle inpatient data sources such as UB and DRGs?
3. What coded information and discrete data will your solution obtain from discharge and procedure summaries?
4. What other data sets and mechanisms will you use to obtain inpatient clinical data?
5. Emergency Department EHR
6. Explain how your proposed solution will create a registry of emergency department visits that contains coded clinical information and claims/billing data on emergency department use. The solution should be initially based on billing, claims and clinical data from Medicaid and commercial health plans.
7. How will your solution make use of direct feeds of hospital emergency department UB data?
8. How will your solution support for data feeds from Oregon’s implementation of a standards-based information exchange for emergency department utilization and individual-level clinical information?
9. Other Provider Records
10. How will your proposed solution make use of records for extended or long-term care, dental, vision, rehabilitation, behavioral health, alternative medicine, and others?
11. Clinical Data Acquisition and Interfaces
12. Describe the methods your solution will use to move data from EHR and other clinical systems to the data service, including batch transfer, file copy, messages, structured documents or other.
13. Clinical Data Transform and Quality
14. Describe the transformation methods you will use for inspecting clinical data and determining whether the quality is suitable for reporting.
15. How will you clean numeric data and make it computable? For example, how are values for blood pressures, bodyweight, and numeric laboratory tests validated and transformed?
16. Will the proposed solution’s clinical vocabulary comply with national standards? For example, will it use LOINC for the following?

(Patient) experience, family history, functional status, intervention, health record components (demographics), laboratory tests, vital signs, preferences, risk evaluation, and system resources

1. Will the solution support ICD-9, ICD-10, and SNOMED coded problems in the provider-submitted patient problem list?
2. Does the proposed solution contain any additional support for SNOMED and other clinical ontologies—including any proprietary methods and coding systems used to assign reporting level concepts to clinical data items?
3. What tools and or data management support does the proposed solution provide for submitting providers to create mappings from their proprietary or custom codes to standardized code sets used in the quality database?
4. What is your proposed migration plan from ICD 9 to ICD 10, including the period when there is overlap?
5. Describe the risks in making the transition.
6. Include estimates of the likely amount of lost or un-coded/un-mapped data.
7. Describe the overall impact to provider quality measurement and assessments of clinical and service performance.
8. Describe how the proposed solution supports using CPT, HCPCS, and HIPPS to encode encounter types, procedures and services.
9. Meaningful Use (MU) Quality Reporting Data Intermediary Functions
10. Describe the capabilities of the proposed solution to receive, store, and maintain clinical and other metrics data on behalf of providers and submit/transmit metrics to Medicare, Medicaid, CCOs, payers and other agencies as directed by providers on their behalf.
11. Describe the capabilities of your proposed solution to accept HL7 QRDA Category I and QRDA Category III Reports from data suppliers (providers).
12. Describe the capabilities of your proposed solution to create Category I reports on supplier’s behalf, based on raw data from data supplier.
13. How does the proposed solution acquire measures in HQMF format from a measure repository or the Measure Authoring Tool (MAT)?
14. Describe the transport protocols and formats (e.g. Web Service, SSL, FTP, HL7 message, Direct) that your solution will use to obtain HL7 structured documents from data suppliers.
15. What capabilities will the proposed solution provide to calculate quality metrics based on QRDA Category I reports received from suppliers, using eMeasure definitions?
16. What capabilities will the proposed solution provide to create QRDA Category III reports containing population metrics for one or more measures?
17. Discuss how the proposed solution will support the Quality Data Model (QDM, <http://www.healthit.gov/quality-data-model>).
18. Discuss how the proposed solution will support HL7 v3 data types.
19. How will the solution securely transmit Category III reports to CMS, other intermediaries, or state agencies?
20. Pharmacy Sources
21. Describe the proposed solution’s capabilities to import, scrub, and manage prescription medication order and fulfillment data.
22. What approaches will the solution use to acquire, manage, and present medication utilization data, including refills?
23. Describe the proposed solution’s abilities to import and manage prescription payment and reimbursement information.
24. Which medication and prescription terminologies will the proposed solution support? (RxNorm, Medispan, FDB, NDC, NCPDP)?
25. Describe the capabilities of the proposed solution to combine information from different clinical sources to report on medication compliance. An example would be to show the percentage of medication prescriptions that were actually filled by patients.
26. Laboratory Sources
27. How does the solution extract, transport, and use clinical lab data in the calculation of quality measures.
28. What sources of clinical laboratory data will be supported?
29. Describe how the proposed solution will import, clean, validate, and manage individual clinical lab test results?
30. How will the solution manage lab result-related data that are important for interpretation, such as testing methodologies, normal ranges, measurement units, etc.?
31. Describe how the proposed solution supports standardized clinical laboratory coding terminologies including CPT and LOINC for laboratory orders and results.
32. State of Oregon Vital Statistics
33. How will the proposed solution acquire and manage individual birth and death certificate information?
34. State Immunization Registry
35. Describe the capabilities of the proposed solution to accept and manage individual vaccination records sourced from the Oregon ALERT IIS.
36. Base Reporting and Analytics

In this section, describe your relevant experience and proposed solutions for base reporting and analytics.

Relevant Experience

1. Provide examples of your experience providing client access to aggregated data for internal quality efforts and using the data to provide reports, both for clients and the public. For whom did you provide these services and when?
2. Describe your experience providing clients access to both aggregated, de-identified data, and patient-level detail. How do clients access analytic and reporting functions? In what formats did you make the data available? What training have you provided?
3. Describe the data query tools your clients used to access the data. What recommended application architecture have you used for base reporting and analytic solutions? What software applications and services were required? What developer and administrator tools are available? How did the analytic solution integrate with one or more databases?
4. What issues have you found when providing clients with access to the data? How have you addressed these concerns?
5. Describe your experience producing public reports or providing data to a third party for public report development. Provide two samples. What issues have arisen? How have you addressed them?

Proposed Solutions

1. Will your solution provide all the preconfigured healthcare quality metrics and reports listed in Appendix A? If not, which ones will you provide?
2. Discuss what additional reports will be made available “out-of-the-box” to support the following types of users:
3. Commercial and CMS health plans (e.g. plans participating in State health insurance marketplaces)
4. Providers, practices, hospitals and health systems
5. State of Oregon Educators Benefit Board (OEBB) and Public Employees’ Benefit Board (PEBB)
6. Oregon Health Authority Coordinated Care Organizations (CCO)
7. Public consumers seeking information about healthcare quality and transparency
8. How will Q Corp analysts obtain access to detailed documentation, standard report definitions, metadata, data definitions, calculations, and algorithm specifications?
9. How will the solution routinely stage all available data (at least quarterly, and preferably monthly), to calculate and report Meaningful Use Measures and variant metrics for the different audiences (providers, hospitals, plans, State, and Q Corp)?
10. Does the solution provide the capability to construct a metrics history file or database for practices and hospitals that track the metrics over time? Metric history should include at least the following:
11. Metric numeric value or score
12. Numerators
13. Denominators
14. Period identifiers
15. Applicable benchmarks
16. How will the base reporting solution support the Q Corp analytics team to create, manage, and modify global assumptions, constraints, and definitions for reports, including:
17. Cases per physician sample size requirements
18. Physicians per practice sample size requirements
19. Initial population definitions
20. Numerator definitions
21. Denominator definitions
22. Denominator exceptions and exclusions
23. How long will it take to specify, develop, test, and deploy a new routine report?
24. Describe your plans for incorporating support for the eMeasure standards (<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Electronic_Reporting_Spec.html>). If it does not already support the standards, when and how will the solution accept measure definitions in HL7 HQMF standard format?
25. What groupers will be available for claim-based analytics? What are the sources of proprietary and standard groupers included in the standard analytics platform?
26. How will your grouping methods support the following types of analyses, based on healthcare claims, clinical data, or both?
27. Cost
28. Utilization
29. Clinical categories
30. Therapeutic classes
31. Episodes of care grouping
32. Severity or case mix adjustment
33. What capabilities will the system provide to identify episodes of care and create groups of transactions related to those episodes?
34. What measures will be provided to enable reviewing and auditing of the following episode-of-care performance?
* Readmission rates by diagnoses and facility (including the admission to a different hospital)
* Hospital discharge—assess post-discharge prescription fills, ER visits, and other service utilization
* ER visit—assess post-visit prescription fills, ER visits and other service
* Multiple invasive procedures on the same patient at different facilities within a defined period of time
* Repeated imaging
* Admission rates following outpatient surgery
1. What are the preferred cost and episode groupers? Are they proprietary? Do they include mental health?
2. Will the solution have the capacity to apply different groupers including a standardized grouper selected by Q Corp?
3. What capabilities will the solution provide to assess case mix or to apply various risk adjustment methods?
4. How will the system support analysis of cost, quality, treatment episodes, and resource utilization?
5. What alternative methods are available for case mix and risk adjustment?
6. What capabilities does the system have to address population health metrics such as overall burden of illness or for specific conditions or episodes of care?
7. Does the analytic system provide the capability to do value analysis by factoring quality and cost simultaneously?
8. Does the analytic system to provide data capture and analytical methods to unbundle a claim or bundle other services for comparison (for example, with hospital inpatient claims – when provided a revenue code but not the detail of services)?
9. How will the solution facilitate analysis of efficiency defined by allowed amounts and/or resource use for defined procedures, with and without provider-specific comparisons to standard price? You may make reference to the following methods:
* Assigning RVUs to specific services (using the standardized groupers)
* Calculation of total cost of care by summing the RVUs
* Optionally, calculating efficiency using allowed and billed amounts
1. How will the analytic solution group and filter metrics based on characteristics of the physicians in the provider directory such as Medical Home Physician, non-Medical Home Physician, Primary Care versus non-Primary Care provider?
2. How will the solution support analysis of the changes in illness burden of the total population or a subpopulation?
3. Advanced and Ad Hoc Analytics

In this section, describe your relevant experience and proposed solutions for advanced and ad hoc analytics.

Relevant Experience

1. Provide examples of your experience offering ad hoc query methods to customers. For whom did you provide these services and when? What tools and techniques were made available? How do you propose to provide standardized ad hoc query capabilities to Q Corp?
2. Describe your process for developing new, customized, ad-hoc reports and graphs.
3. Describe your experience providing researchers with access to the data. How have you managed patient identifiers? Is the system able to provide “proxy” dates and other mechanisms to create limited or de-identified data sets, well maintaining the suitability of the data for research? Is it possible to re-identify patients if necessary?

Proposed Solutions

1. How will the solution allow analysts to develop reports and analyses, based on a broad spectrum of calculated metrics and multiple dimensions?
2. What documentation will be available for the reporting data model?
3. What support will the solution provide for prospective modeling and what-if analysis?
4. What data visualization and tools for exploratory analysis will be provided as part of the solution?
5. What statistical capabilities will be provided, including parametric and non-parametric tests, hypothesis testing involving subgroups and populations, linear regression, time series, measuring sample sizes and power, reliability, and others?
6. What support will the solution provide for the export of data into other statistical data visualization and exploration tools, including file formats for export, such as SAS, SPSS, R, Excel, PDF, and others?
7. What secure file transport mechanisms will be provided to move data from the data service to a separate analytics platform, or to an analyst’s local environment?
8. Portal Services

In this section, describe your relevant experience with and approach to creating portal services.

Relevant Experience

1. Provide details about your experience offering access to data and reports via a secure web portal. Include examples of how the portal helped to maximize the capabilities of aggregated data and other resources. Provide screenshots or examples.
2. What types of users are best served by the reporting portal?
3. What types of data were made available, and how did it benefit the practices?

Proposed Solutions

1. Provider Registration and Participation
2. How will your proposed solution handle provider registration and participation agreements? The following data must be collected:
* Provider first and last name
* National Provider Identifier (NPI)
* Practice address
* Specialty
1. How will your proposed solution handle portal access for providers? Address the levels of a hierarchical portal access structure (user level hierarchies), including medical group user, clinic-level user, and provider-level user. How will your solution manage different permissions and/or views for each user level?
2. Provider Directory Services
3. Describe the underlying database structure and data elements that will be stored and used in the portal provider directory. Address how the portal directory will conform to the IHE technical framework for Healthcare Provider Directory (HPD) CP601, and the HPD Plus v1.1 relational model. <http://wiki.ihe.net/index.php?title=Healthcare_Provider_Directory>, <http://www.ihe.net/uploadedFiles/Documents/ITI/IHE_ITI_Suppl_HPD.pdf> , <http://exchange-specifications.wikispaces.com/search/view/HPDplus>.
4. How will the directory be made available online through a secure web portal?
5. Patient Registry and Record Location Services
6. Describe the functionality for participating providers to query and identify possible sources or locations of information about a patient. How will the proposed solution handle patient look-up and record locator service (RLS) through the portal?
7. How will the proposed solution provide access to participating providers (medical groups/clinics, hospitals, emergency departments, and others) to enable them to see the full encounter, services, and medical history using claims history for a patient record that has been identified through the portal?
8. What privacy safeguards will be available to support patient consent to use data under HIPAA (<http://www.hhs.gov/hipaafaq/use/>)?
9. How will the proposed solution enable audit of access to patient records?
10. Organization of the Provider Measure User Interface
11. How will the reports be organized and presented? For example, categories by measures of type, provider, or other categories.
12. What dashboards will the solution provide for quality measure areas such as adult, pediatric, required, menu sets, and so on.
13. Describe the proposed solution’s ability to run parameterized and filtered queries from a simple user-interface.
14. How will the proposed solution enable a provider to save, organize, and recall parameterized and filtered queries as “standard” reports?
15. Measure Content
16. What specific standard CQI measures will be supported by the proposed reporting portal, including NCQA- and NQF-endorsed measures?
17. How will the solution enable standardized measure content and report functionality extension by the administrative user (not the vendor)?
18. What type of work will be required to add customized measures, such as provider practices and hospital measures, Oregon CCO measures, and others specified in Appendix A?
19. How will your solution support and be extendible to cover medical specialties, perinatal care, and pediatrics?
20. Dimension Hierarchies
21. How will the proposed system set up and display drill paths? For example, how would the drill paths from hospital/health system, to medical group, to individual practice, to physician, to patient be implemented? Other common drill paths could include:
* Insurance type
* Geography, such as county
* Date ranges, such as year, quarter, or month
1. Incorporation of External Reference and Benchmark Data
2. How will the proposed solution be able to augment provider and clinic patient counts and percentages with contextual statistics such as the following?
* Numerator and denominator
* Medical group average
* Confidence intervals
* Oregon average
* Oregon benchmark
* HEDIS 90th percentile benchmark
* Users selected control limits
1. Trends and Time Series
2. How will the proposed solution display measures over time? What arbitrary time periods or date ranges will users be able to select to display data historically? How will you facilitate medical practices to run historical trend reports on quality measures to track progress?
3. Patient Disease-Specific Registry Function
4. How will your solution create condition-related registries of high cost/high use patients defined in terms of specified conditions, high utilization rates, and total costs?
5. What key conditions will be tracked in metrics, for example, diabetes, asthma, COPD, CHF? What cost and utilization metrics are available?
6. How will the solution facilitate the management of individual patients missing from the numerator of a measure or report?
7. How will the proposed solution highlight patients as missing from the numerator, indicating a care gap in the data?
8. What will be the drill path to detailed patient information?
9. How does the proposed solution enable patient data to be exported or integrated into a workflow that allows remedial actions such as outreach or exception reporting?
10. Export Formats
11. Describe the proposed workflow for exporting data from the web interface to Excel, a delimited file, or PDF for each of these data sets:
* Patient level data
* Provider level
* Practice level data
1. Provider Feedback/Correction Form for Discrepancies
2. Show how your solution will enable hospitals, health systems, and providers to report perceived discrepancies between their clinical data and the reports in the portal. Describe the process by which the following tasks will be performed. Include screenshots or copies of forms that are currently in use.
3. Show how a provider will be able to submit detailed information on an individual patient.
4. What will the process be to review and process provider-submitted discrepancy information?
5. How will the administrator assess discrepancies and make corrections in the data?
6. Will the administrator have the capability to capture a history of data corrections and apply them to subsequent rounds of reporting?
7. Public Reporting
8. Describe how subsets of approved measures will be made available for public reporting across physician groups or health systems.
9. Portal Administration
10. What administrative reports will be available for the portal? Discuss and demonstrate support for the following. You may use screenshots of example reports to demonstrate reporting capability in the RFP response.
* Traffic: Page hits by month
* Discrepancies reported—as listed in (K) above
* Report execution: report name, time, user, clinic, provider
* Data volumes (counts of patients, claims, enrollment, providers by type, medication claims, EHR data)
* Profiles of patient characteristics (by age, demographic characteristics, insurance type, diagnosis, and others)
* Profiles of provider characteristics, portal access, and usage statistics
* Audit access to patient record disclosures by page view, download, export, messaging, and others (see Section VI below for additional privacy policy requirements)
* Ability to generate and view the entire cumulative record for each patient, with a delineation of sources (HIPAA-specified Designated Record Set)
* Roster export: allows provider directory freeze for provider attributions
	+ Unique provider ID
	+ Medical group, clinic name
	+ Region
	+ NPI
	+ Provider name
	+ Address
* Medical group contact export
* Roster transaction log—audits any changes to the provider directory
1. Change Orders and Enhancements
2. Describe the mechanism for making fundamental updates to the measures and dimensions available in the reporting portal.
3. Describe the mechanism for portal defect management, new features, and major/minor upgrade push/release schedule.
4. Describe the support mechanisms you will use with Q Corp, to include change requests process, telephone availability, incident response and closure, etc.
5. Explain how the Q Corp can be made self-sufficient with the portal management.
6. What technology is used to program the portal? (For example, Drupal, Ruby, proprietary?)
7. Data Refresh Frequency
8. How often will the data in the portal be refreshed from the data service?
9. What will be the maximum latency between the supplier updates and all databases used in the proposed solution?
10. What is the duration of the processing window for loading data and rebuilding cubes? Indicate how much downtime Q Corp will experience.
11. Data Submission from Portal Database
12. Describe how the portal will be used to submit the data to state or federal agencies in support of meaningful use reporting, quality data registries, or other quality measurement initiatives. Address how it will include support for QRDA I and III and eMeasure formats.
13. Direct Data Entry of Summarized Hospital, Health System, or Physician Practice Data
14. Describe how the portal will provide sequential guidance to provider staff, for example a highly structured form, or “breadcrumbs,” when submitting measures from a menu set suitable for the creation of an HL7 QRDA III Structured document.
* Numerators, denominators, exceptions, and exclusions
* Core attributes of the practice
* Feedback to the provider on benchmark attainment
* Data source description
* Definition of the period covered
* Reference to the measure definition
* Provider attestation of the accuracy and validity
1. Additional Provider Support and Guidance to Assist with Selection and Reporting of Metrics for the Oregon Patient Centered Primary Care Home Program
2. What will be the mechanism to input alternative metric numerator/denominators through the portal that could later be used/retrieved for the PCPCH application process?
3. How will you provide for PCPCH applicants to review their metrics results and history online to help with selection of metrics for use in the PCPCH application process?

# Privacy and Security Protections

## Privacy and Security Requirements

The data service vendor will maintain compliance with HIPAA, the Privacy Rule (45 CFR part 160 and part 164, subparts A and E) and the Security Rule (45 CFR Parts 160, 162, and 164), and the HITECH Act. The vendor will provide information about policies and practices related to the use and disclosure of PHI; implementation of appropriate safeguards; mitigation of harmful effects, documentation and reporting of any use, disclosure or breach; ensuring that agents and subcontractors agree to the same restrictions and conditions; providing access to individual designated record set; availability of internal practices, books, and records, including policies and procedures; accounting of disclosures; and other privacy and security-related practices.

Q Corp intends to support the legal agreement framework shown in Figure 3. The Data Services Vendor will engage with Q Corp under a service contract and a Business Associate Agreement with Q Corp. 

Figure 3 Q Corp Legal Agreement Framework

Q Corp and its Data Services Vendors will meet privacy and security requirements in the following four domains:

1. **Private Sector**—defined as all requirements pertaining to Business Associate Agreements (BAA) of Q Corp, its data suppliers, partners (such as analytic service providers or technology partners), and other authorized private, non-profit, academic, and/or commercial users (“customers”) of the data.
2. **CMS Medicare Certified Qualified Entity (MCQE)**—defined as Standard 3, Data Security and Privacy requirements. MCQEs such as Q Corp must demonstrate that they have rigorous security and privacy practices in place to protect the data released to them and that they have programs in place to enforce and monitor data security practices. Stringent security and privacy standards must be enforced throughout all phases of the program, including data receipt and transmission, performance measure calculation, the provider review and corrections process, and performance reporting (including all public reporting as well as any other types of more limited reporting). Appendix B of the CMS Information Security (IS) Acceptable Risk Safeguards (ARS) details the security controls: <http://www.cms.gov/informationsecurity/downloads/ARS_App_B_CMSR_Moderate.pdf>
3. **Oregon Health Authority**—defined as requirements for compliance with administrative rules implementing HIPAA business associate requirements (OAR 943-014-0400 to 943-014-0465). Q Corp must ensure that any agent, including a subcontractor, to whom it provides protected health information or electronic protected health information created, received, maintained or transmitted by it on behalf of the Authority agrees to the same restrictions and conditions that apply through these rules and the contract to business associate with respect to such information (for additional detail, please reference attachment OAR943-014-0400--0465-BAAs.pdf).
4. **Additional specialized privacy and security requirements** —defined as requirements to be determined at future dates in response to Q Corp contracts and business objectives. Q Corp will require the Data Services Vendor to make contractual commitments to comply with specialized privacy and security requirements, as they become known.
5. General Questions on Privacy and Security

Please provide examples of your experience ensuring the privacy, security and confidentiality of all information and data submitted by clients similar to Q Corp. For whom did you provide these services and when? How do you propose to provide privacy and security protections for Oregon?

1. Describe how you and your clients have addressed HIPAA concerns when aggregating, analyzing, and reporting data from multiple entities. How have you ensured HIPAA compliance when working with Protected Health Information (PHI), limited data sets, and de-identified data?
2. What is the mechanism to exclude individual patient data from Q Corp reporting if requested by the patient?
3. How have you handled so-called "sensitive" information, including records that refer to treatment for HIV/AIDs and other sexually transmitted diseases, treatment for substance abuse, mental health issues, and genetic information?
4. Describe your physical, technical, and administrative security policies, procedures, and practices. Describe how you enforce and monitor these policies and procedures. Have external security experts reviewed those policies and procedures and your monitoring/enforcement practices to evaluate their adequacy?
5. Describe how you test, audit, upgrade and back up your systems and how often. How often do you perform (or have an experienced consulting company perform) external penetration tests? Internal network security audits? How have you tracked record access history in order to comply with HIPAA?
* Describe the accounting of disclosures mechanism used by your system.
* How are individual accesses and views of patient information provided back to the patient?
1. Describe your experience using third parties outside your organization to process or access client and/or patient data. What protections are in place when using third parties?
2. Describe your proposal for the privacy and security protection function, including indemnification of Q Corp in the event of privacy breaches.
3. Provide any relevant certifications relating to healthcare privacy and security, for example eHealth Trust, HITRUST, EHNAC, and others.
4. Support for Medicare Certified Qualified Entity
5. Do you have experience in demonstrating compliance with the minimum data security requirements for Standard 3 of the Medicare Qualified Entity Certification Program (QECP; <https://www.qemedicaredata.org>)?
6. Do you warrant that your company has current, documented policies and procedures in place that will be reviewed annually, for each of the detailed elements of the QECP Standard 3?
7. Will you comply with requests to audit compliance with QECP Standard 3?
8. Describe, at a high level, your policies and procedures for each of the following QECP Element details:
* Audit and Accountability (AU) Controls
* Security Assessment and Authorization Controls (CA)
* Incident Response (IR) Controls
* Planning (PL) Controls
* Risk Assessment (RA) Controls
* Access Control (AC) Controls
* Security Awareness and Training (AT) Controls
* Configuration Management (CM) Controls
* Identification and Authentication (IA) Controls
* Personnel Security (PS) Controls
* Contingency Planning (CP) Controls
* Maintenance (MA) Controls
* Media Protection (MP) Controls
* Physical and Environmental Protection (PE) Controls
* System and Services Acquisition (SA) Controls
* System and Communications Protection (SC) Controls
* System and Information Integrity (SI) Controls
1. Questions on Generating De-identified and Limited Data Sets
2. Describe/document the methodology used to generate de-identified (“safe harbor”) data sets according to 45 CFR 164.514 (b) (2).
3. Describe/document your ability and methodology used to generate limited data sets as described in 45 CFR 164.514 (e)
4. If you use the "expert determination" method as described in 45 CFR 164.514 (b)(1), what contractual guarantees and protections will you put in place to ensure the integrity of the audit? Please name the external auditor(s) used to provide statistical evidence that the data cannot be identified alone or in combination with other data sets.
5. Question on Secure Transport of PHI
6. How does your solution secure data at rest, data in motion, and data in use? Please address each item individually and include the name or type of encryption algorithms, tools used, and other pertinent information.

# Contractual Issues

Address the following contractual issues.

1. Provide examples of legal and financial commitments you have made with existing clients. How do you propose to address these issues for Q Corp?
2. Non-compete: Q Corp will not agree to the vendor re-marketing jointly developed solutions to Q Corp’s direct competitors.
* Describe your approach to providing products and services to entities in Oregon that may compete directly with Q Corp.
* Indicate your approach to setting limits on the potential to re-market solutions to Q Corp’s competitors, particularly any solutions that will be co-developed under contract to Q Corp.
1. Considerations of Shared/co-developed Intellectual Property: Q Corp will assert ownership of jointly developed intellectual property.
* How will you document and protect new functionality, systems, extensions, customizations, processes, algorithms, outputs, and other solution components developed in collaboration with Q Corp, including new solutions for the requirements specified in this RFP?
* How will you ensure the rights of Q Corp to use, maintain, and enhance co-developed solutions in perpetuity?
1. Provide details on any offshore contractors, subcontractors, or partners; particularly those that may have access to protected health information.
2. Indemnification to protect clients from inaccurate data/reports or erroneous data.
3. Conflict resolution process (business-level legal or contract-related resolution process).
4. Termination and transition plans.
5. Attach your standard Contract, any terms and conditions, and your software/service license.

# Project Management, Services, and Support

1. Account Relationship Management
2. What is your recommendation for the best approach to a collaborative relationship?
3. Describe your approach to offering creative customer service solutions – for example, co-locating a representative on site.
4. What is the imagined staffing model?
5. Project Management
6. Describe the resources required from the client and your company during the implementation. Indicate roles and skills required.
7. List any approved or recommended consulting organizations that can assist with implementation services.
8. Describe the project management tools and methodology used by your company. Include sample project plans.
9. Describe the experience level, tenure, and certification of your project managers and implementation consultants.
10. Describe procedures for acceptance testing.
11. Training/Documentation
12. Describe how system documentation is provided. For example, will it be online and accessible over the Internet?
13. Describe how training is provided, in particular for administrators and analytic users of the database.
14. Support Services
15. Describe the procedure customers follow to report problems. Include a discussion of methods of contacting the support center, the escalation process, and location of support resources.
16. What are the hours of normal support (note Q Corp is on Pacific time)? Indicate the availability of support resources after normal business hours.
17. Describe how updates, enhancements, and new releases are deployed.
18. Detail how the customer can submit product enhancement requests.
19. Detail any support or maintenance for the system that is provided by other companies.
20. Implementation and Other Mechanisms for Project Management, Staffing, Support, Change Management, Conflict Resolution

It is likely that additional core business service and functionality requirements will emerge over the course of the anticipated contract. The needs of Q Corp and its customers may change during the term of implementation and services.

1. How will you work cooperatively with Q Corp to jointly define work scope and contract amendments to incorporate the necessary data, data structures, and functionality necessary to support newly defined state, federal and private-sector reporting requirements, such as future stages of the EHR Meaningful Use Incentive Program?
2. Describe your change order process.
3. What types of changes and extensions are included in the base price and contract?
4. What changes are outside the scope of the base price?
5. How will you ensure sufficient project resource and management capabilities to meet the task- and deliverable-based implementation schedule?
6. Q Corp will only support schedule adjustment or modifications as mutually agreed. What process do you use to engage customers in proactive project scheduling?
7. What performance incentives or penalties have you encountered to ensure on-time service levels or deliverables?
8. Describe what project management approach is used, and the steps taken to ensure communication is proactive, timely, and accurate.
9. What steps or remedies are available to Q Corp in the event that purchased and implemented products and services do not meet Q Corp’s specified needs?
10. How will you ensure sufficient staffing is sufficient for engineering, implementation, and project management?
11. What proactive steps will you take to advise Q Corp in the event that, in your expert opinion, Q Corp staff and resources are not sufficient for timely project management and coordination?
12. What remedies do you offer in the case of delays in product/service implementation and acceptance?
13. What remedies do you offer in the case that Q Corp acceptance testing process does not detect gaps in actual (implemented) vs. required functionality?
14. How will you ensure that your account management team remains responsive has incentive to negotiate remedies for product and service implementation delays or shortcomings?
15. Describe how you have handled collaboration between your company and multiple technology vendors to provide a customer solution. What key processes will you have in place to ensure that vendor collaboration on core business services is sufficient, effective and timely enough to meet service/implementation schedules?
16. What is your desired conflict resolution process for project-level management, technical issues, and implementation?

# Financial

## Vendor Cost Proposal

Provide a detailed cost proposal, substantially in the form of Cost Attachment 1 with an appropriate narrative of the identifiable cost elements to accomplish the full spectrum of services in the proposed solution. The narrative should describe your overall approach to pricing the solution(s) offered as well as describe the various cost elements. Indicate the key volume or scope assumptions that affect the proposed costs.

Note that Year 1 costs for implementation, transition, and initialization are grouped separately from the Year 1 operating costs. Cost Attachment 1 requests (a) costing information across the five substantive areas of the RFP for Years 1 and 2, (b) information on changes in costs for Years 3-5 that would be different than the Year 2 costs, and (c) costing methods and rates for change orders.

Refer to the provided document entitled Vendor\_Cost\_Proposal.xlsx

### Cost Attachment 1—Vendor Cost Proposal XLS, Sheet 1: Cost Proposal

You may respond to some or all of the columns in Sheet 1, keeping in mind the following guidance:

1. Q Corp intends to select a single database vendor for both claims and clinical data. If you intend to provide database services, please respond to both columns D and E in the costing spreadsheet (Sheet 1).
2. You may choose whether to respond to none, some, or all of the items in columns F-H (base reporting, advanced ad hoc analytics, and portal services), depending on your product offerings in those areas.

### Cost Attachment 2—Vendor Cost Proposal XLS, Sheet 2: Payment Proposal

Provide a performance plan with a “deliverables and task-oriented” payment schedule, including total all-inclusive pricing; an example is shown in the payment schedule spreadsheet (Sheet 2). If you wish, you may propose an alternative format for this part of the response. Please explain and document your assumptions thoroughly.

1. Base Measures

Refer to the spreadsheet, Appendix A1\_Base\_Measures.xlsx for a list of base measures.

Refer to the PDF document, Appendix\_A2\_Perinatal\_Measures.xlsx for perinatal measures.

1. Data Supplier Data Layout

The OHQRS accepts data in two formats:

1) Format shown in Appendix\_B1\_QCorp\_Data\_Submission\_Format.docx

2) Oregon APAC Data submission specification Appendix\_B2\_APACdatalayoutfinal\_10-31-11, available at:

[**http://www.oregon.gov/oha/OHPR/RSCH/docs/all\_payer\_all\_claims/datalayoutfinal\_10-31-11.pdf**](http://www.oregon.gov/oha/OHPR/RSCH/docs/all_payer_all_claims/datalayoutfinal_10-31-11.pdf)

1. Example Work Plan

**Phase I**

| Milestones | Activities |
| --- | --- |
| Establish business and community partnerships, plans, and management systems | Identify health plan and clinic partnersSecure Financing commitments Appoint measurement and reporting team Agree on measures and measurement specificationsCreate staffing plan for data analytics and technical management |
| Establish technical partnership with one or more vendors**(“MONTH 0”)** | Select vendorsContract with vendorsCreate work plans and program management processes  |
| Develop legal protocols**(“MONTH 1”)** | Ensure compliance with HIPPA Sign legal agreements with plansSign legal agreements with providers |
| Develop and execute data migration plan **(“MONTH 6”)** | Coordinate with existing vendorDevelop migration processObtain and stage data for reportingConduct one round of parallel reporting with comparison metrics |
| Collect and report Round 1 *Claims* data to clinics and health plans**(“MONTH 10”)** | Establish communication channels and processes for data submissionIssue data call and submission proceduresBuild physician/clinic attribution crosswalk and methodologyFeedback loop with clinics to clean data and crosswalkIssue consolidated patient-level report to clinicsCleaned and modified files returned to plans with physician attribution and claim integrity information by clinic and blinded provider and clinic quality measures |
| Collect and report Round 1 *Clinical* data to clinics and health plans**(“MONTH 12”)** | Determine high-level process for clinical data reportingEstablish communication channels and processes for data submissionIssue data call and submission proceduresBuild physician/clinic attribution crosswalk and methodologyFeedback loop with clinics to clean data and crosswalkIssue consolidated patient-level report to clinicsIssue consolidated report to health plans with physician attribution and claim integrity information by clinic and blinded provider and clinic quality measures |
| Review and assess processes with stakeholders**(“MONTH 13”)** | Request stakeholder feedbackConduct a financial assessmentConduct a vendor assessmentAddress critical decisions for proceeding |

**Phase II**

| Milestones | Activities |
| --- | --- |
| Collect and report Round 1 *Claims* data to clinics and health plans**(“MONTH 15”)** | (Repeat) |
| Collect and report Round 1 *Clinical* data to clinics and health plans**(“MONTH 15”)** | (Repeat—add auditing functions as appropriate) |
| Public reporting of claims and clinical data **(“Month 16”)** | Measures will feed into a website to encourage consumer engagement. Creation of meaningful education and messages for consumers around the measures. Report/display/use the quality data for consumer engagement.Integrate with self-management programs.Plan for the evolution of this process, for example the ability to integrate with a common platform across 14 other likely communities. |
| Patient experience data collection | TBD |

1. List of Participants

The list of currently participating data suppliers is available at the Q Corp website at <http://www.q-corp.org/about/partners-sponsors>

1. Certifications and Assurances
2. I/we make the following certifications and assurances as a required element of the proposal to which it is attached, understanding that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to the award or continuation of the related contract(s):
3. I/we declare that all answers and statements made in the proposal are true and correct.
4. The prices and/or cost data have been determined independently, without consultation, communication, or agreement with others for the purpose of restricting competition. However, I/we may freely join with other persons or organizations for the purpose of presenting a single proposal.
5. The attached proposal is a firm offer for a period of 60 days following receipt, and it may be accepted by the Q Corp without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 60-day period.
6. I/we understand that the Q Corp will not reimburse me/us for any costs incurred in the preparation of this proposal. All proposals become the property of the Q Corp, and I/we claim no proprietary right to the ideas, writings, items, or samples, unless so stated in this proposal.
7. Unless otherwise required by law, the prices and/or cost data that have been submitted have not been knowingly disclosed by the Bidder and will not knowingly be disclosed by him/her prior to opening, directly or indirectly to any other Bidder or to any competitor.
8. I/we agree that submission of the attached proposal constitutes acceptance of the solicitation contents. If there are any exceptions, I/we have described those exceptions in detail on a page attached to this document.
9. I/we grant the Q Corp the right to contact references and others who may have pertinent information regarding the Bidder’s prior experience and ability to perform the services contemplated in this procurement.
10. I am authorized to bind the Proposer to a contractual relationship, e.g., the President or Executive Director if a corporation, the managing partner if a partnership, or the sole proprietor if a sole proprietorship.

|  |
| --- |
| Vendor's Name: |
| Title:  |
| Vendor's Signature: |
| Organization Name: |
| Mailing Address: |
| City: State: Zip Code:  |
| Telephone: Fax:  |
| Email address: Website:  |
| Federal Tax No:  |

1. Available at <http://q-corp.org/reports/statewide-reports> [↑](#footnote-ref-1)
2. <http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf> [↑](#footnote-ref-2)