Delaware Health
And Social Services

DIVISION OF MANAGEMENT SERVICES

PROCUREMENT

DATE: March 11, 2018

HSS 19 029

HEALTHY WOMEN HEALTHY BABIES 2.0
FOR
DIVISION OF PUBLIC HEALTH

Date Due: April 2, 2019
11:00AM

ADDENDUM # 1 Please Note:

THE ATTACHED SHEETS HEREBY BECOME A PART OF THE ABOVE MENTIONED BID.
Responses to questions received by the deadline of February 18, 2019 and asked at the Pre-bid meeting March 1, 2019.

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Healthy Women Healthy Babies 2.0

HSS 19 029

Questions and Answers

1. **How long is the participant enrolled? And at what time does the participant start that enrollment? And how frequently do they need to be re-enrolled?**

   Answer: Contract terms with the selected vendors will begin on July 1, 2019. HWHB 2.0 starts at baseline zero. Participants in the present program will not rollover to HWHB 2.0.

   A woman is in the program as long as she needs the services. Each participant will be assessed for re-enrollment in the program on an annual basis.

2. **How do we define a new enrollee? Do we start at zero in July FY20 for a new contract?**

   Answer: A new enrollee is a patient that is screened and deemed eligible (per the eligibility criteria) for the HWHBs 2.0 program. In your proposal, propose and outline strategies describing how you will conduct outreach and engagement and retain the enrollees in the program to have them come back. DPH is looking for innovative strategies (i.e. group education) and solutions proposed to keep that woman engaged in the program.

3. **Are there a certain number of visits required within the enrollment period?**

   Answer: It depends on the client's identified health needs and the provider's medical assessment. Ongoing preventive care, family planning, psychosocial support as well as interconception care are important to address the risks of women to optimize the health of women before, between and beyond pregnancies.

4. **Do we get $35 per month for the patients enrolled in the program?**

   Answer: The $35 baseline payment is one time. $35 is paid per patient upon entry into the program. It is not reimbursed on an ongoing monthly basis. In addition, each provider will need to select benchmarks, set a baseline, performance targets and demonstrate progress through data collection and reporting in order to receive bonus payment incentives.

5. **All present women in the HWHB program would need reset for HWHB 2.0, or re-enrolled into the program July 1?**

   Answer: Yes, a woman will have to qualify for HWHB 2.0 based on eligibility criteria established and outlined in the RFP and is enrolled in the program under the new contract.

6. **Until they show up for a visit, they are not re-enrolled?**

   Answer: Correct.

7. **A patient could be in the program from age 14-44 no matter if she is being seen for preconception, inter-conception or post-partum?**

   Answer: HWHBs 2.0 is an outcomes oriented/performance-based contract and providers will be incentivized based on meeting benchmarks. There are no "Bundled" services in HWHB 2.0.

8. **A provider would get paid $35 once per woman upon entry into the program and then the provider would get reimbursed based upon the benchmarks for that patient?**

   Answer: Correct.

9. **If a provider selects hypertension as a benchmark and measures hypertension, one time does that meet the benchmark?**

   Answer: For this benchmark, the provider must define the measure, set a performance target, and therefore demonstrate that hypertension is lowered. Throughout the term of the contract, the vendor will revisit the performance targets, and set new ones if they are met.

10. **There are contradictions in the benchmarks; if a provider selects obesity and the woman becomes pregnant her BMI will increase and the provider fail a benchmark?**

    Answer: DPH is looking for the providers to select benchmarks and propose the defined metrics, baseline and performance targets. The new model is looking for improvement as defined in your proposal. For example, care will be tailored to each patient to have a healthy BMI.

11. **How do I measure my screenings for inter-pregnancy interval questions to get to 100% for this RFP? Do I have to ask her this every month I see this patient?**

    Answer: ACOG (https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Prepregnancy-Counseling) recommends that a pregnancy intention screening question (PISQ) be asked at every visit with a woman (i.e. "every women every time"). Please describe an algorithm on incorporating the PISQ into your practice workflow in your proposal and a proposed pathway and plan of care depending on the answer of the patient.

12. **Is the incentive based on individual patients or patient population in relation to the benchmarks?**

    Answer: This is dependent upon which benchmark is selected and how the provider defines the measure and performance target.

13. **Do you want us to select benchmarks for patient population or select benchmarks per patient?**

    Answer: Include a description in your proposal which benchmarks you wish to work on.

14. **If a patient does not have insurance a provider would get $35 then we select 5 benchmarks; are the benchmarks unique to that patient or we select 5 benchmarks in our proposal? If that person does not qualify for the benchmark we selected we can't switch? How do you get paid?**

    Answer: In your proposal, please select five benchmarks. This is a partnership. As we work with you, monitor data, offer technical assistance and have quarterly operational meetings, we will be having opportunities for dialogue to discuss successes, challenges and best practice solutions. DPH in partnership with the providers will review how each provider is making progress on the benchmarks selected. If benchmarks are not being met, there may be modifications or contract amendments.

15. **How do I get paid for this patient if they don't have Medicaid?**

    Answer: This program is not based upon fee for service or for each patient encounter. The patient's income or insurance coverage is not a criteria for program eligibility. This is a performance based and outcomes oriented contract, which incentivizes providers based on meeting or exceeding benchmarks.

16. **In the new model, a patient could be in the program for 20 years; do we need to do a reassessment at any point?**

    Answer: A woman will have to qualify for HWHB 2.0 based on eligibility criteria and be enrolled in the program under the new contract and re-assessed on an annual basis.

17. **It sounds like the benchmarks are critical and you can get reimbursed for the benchmarks. Several of the benchmarks are at 100% and this is not evidence-based for the populations we serve and will never be achieved. How flexible are you with the contractor proposing their own set of benchmarks?**

    Answer: Please analyze your current data and please use the best evidence, specify what you have seen historically and define for your patient population how to achieve or exceed the benchmarks, by setting realistic targets.

18. **Regarding the Benchmarks, for instance substance abuse, if we see a patient and address this and refer them to a community health worker for follow up, does the follow up by the community health worker count or does the patient have to come back into the office?**

    Answer: Layout your innovative approach and strategies to engage this population; define the measure, and establish baseline and performance targets. In addition, list strategies on how can you achieve those targets.

19. **Getting data is going to be challenging. How do we determine the patient population in our present EHR (Electronic Health Record) to show interval change within the timeline to submit the RFP?**

    Answer: Data will be critical to measuring improvement. Please outline how you will obtain this data and report on it on a regular basis and frequency. You will have to propose a solution. There are different ways to collect, track and report data. For example, data

extraction from the EHR, data entry into Redcap, Excel spreadsheet, or whatever means necessary that works best for your practice.

20. For this first year, since we may not understand the challenges with this model we can set low targets and this would be acceptable?

Answer: Please submit your best proposal. If your practice does not show effort in setting accelerated outcome based performance targets, this is doing a disservice to the intended high risk client population. The HWHB 2.0 Program is looking for innovation and impact. This is a paradigm shift from Quantity to Quality. Through HWHBs 2.0, DPH is seeking to implement small tests of change and plans to work with providers to improve health outcomes for women and babies.

21. Are the community health workers embedded in our sites or in the communities?

Answer: The community health workers will serve as a liaison between health/social services and will be family-centered and intentionally placed in high risk communities. They serve as a voice of the community and will work collaboratively with the provider care team. CHWs extend the reach of providers into underserved communities.

22. Would we be expected to develop a relationship and work together closely with this community health worker?

Answer: Yes, community health workers will be expected to engage women and work with the program participants and the care team as well as support social support needs, advocacy, and health and wellness education and referral.

23. Do we have to work with the appointed community health worker or could we work with our own?

Answer: We will work with each provider to ensure we have build capacity and deploy enough community health workers for the providers selected for HWHB 2.0.

24. Would these community health workers be state employees with state benefits?

Answer: No, they would be employed through contractors/ sub-contractors.

25. The community health workers will need to be permitted into our sites, to have access to our HER?

Answer: The Community Health Workers will need access to provider sites. Please describe what access you see is necessary to support these women and help improve outcomes.

26. Do we get to interview them?

Answer: “Interview” may not be the correct term, but a matching process will likely be developed and the provider would work with the community health worker contracted entities who are involved in the same community that the health care provider serves.

27. I have seen harm caused by community health workers as there is not an intermediary overseeing their job performance. In regards to benchmarks, part of our success is tied into the community health worker and what happens if this relationship is not successful?

Answer: The community health workers will be trained on comprehensive standard curriculum. As the workers connect with women and become oriented to your program the hope is that they will be the cultural bridge and have greater understanding of the services you offer and the scope of your practice.

28. Is the RFP for the community health worker tied to these benchmarks and incentives?

Answer: Please see RFP HSS 19 018 Healthy Women Healthy Baby Zones for details and information.

29. Will the community health worker do referrals?

Answer: Yes.

30. We will no longer be reimbursed if we send a patient for psychosocial?

Answer: Correct. The new model does not include a bundle reimbursement and payment structure. The new model is a performance based/outcome oriented contract based on achieving or exceeding benchmarks.

31. This model may fail; we don't understand the financial reimbursement.

Answer: DPH does not want a provider to fail. The new model is a paradigm shift from quantity vs. quality. HWHBs 2.0 is a performance based/outcome oriented contract and incentivizes providers based on achieving or exceeding benchmarks.

32. Do we build in salaries for the people that will provide the service under the new RFP?

Answer: HWHBs 2.0 is not structured to reimburse for staff salaries or staff infrastructure. Please outline foreseen challenges in your proposal.

33. Will each community health worker be assigned to a specific organization or will there be crossover between the community health workers?

Answer: DPH's intent is to increase capacity for each high-risk area.

34. The community health worker will come from different agencies? They will have the same training. They will have different supervisors.

Answer: DPH currently contracts with three different agencies to deploy community health workers; while they have unique supervisory oversight per vendor, DPH develops shared learnings, professional development and opportunities for centralized wrap-around training as well as networking.

35. If three providers share, a community health worker and we each have a different approach to hypertension this community health worker has to understand each of our medical philosophies? What if a patient gets redirected to another practice?

Answer: This will have to be addressed on a case by case basis and relationships will be built over time.

36. How do you determine if I get a whole community health worker or if I have to share that worker with another practice?

Answer: Capacity to meet unique health needs will be monitored and addressed as HWHBs 2.0 evolves.

37. As we go through this process of putting forward a Proposal to meet the benchmarks we select but after the contract starts realize another provider has thought of a more innovative and practical approach can we change our benchmarks or our focus?

Answer: We will work with each provider during contract negotiations and this will be a learning collaborative approach. As we are learning along the way there will always be opportunities to perfect it and improve the model. Put forth your best proposal, and during negotiations items may be refined as well as along the contract year.

38. Will you select options from the vendors? Option A, vendor will do….; Option B, vendor will do….; Option C, vendor will do…?

Answer: As long as the proposal is clear, concise and meets the scope of services in the proposal.

39. Are the Perceived Stress Scale and Patient Health Questionnaire required?

Answer: No. You may use whatever evidence based or promising screening tools available and that works best for your practice to reach program benchmarks.

40. If we took a phased approach with regards to funding for the first program year, could we protect our monthly historical revenue while still selecting benchmarks for the new program?

Answer: Please outline in your proposal and plans will be reviewed during contract negotiations. This is also dependent upon available state funding.

41. Or could we do data gathering for 3-4 months, develop our approaches but still receive a codified billable amount as we transition to new program vs. failing and learning?

Answer: No, this model is moving from quantity vs. quality. The new model does not include bundled reimbursements per patient visit. Please outline foreseen challenges in data gathering in your proposal. During contract negotiations, DPH will work with providers on a reasonable timeline for implementation and milestones for the new model.

42. There is a lot of front end loading without a lot of outcomes and this could set us up for failure. What happens if this fails?

Answer: If the present scope of service needs to be adjusted over time, the quarterly meetings will serve to implement changes and address challenges as they arise which is why attendance at the quarterly meetings will be structured as a learning collaborative and will be mandatory.

43. If one provider is obesity and hypertension focused but we are healthy birth weight focused, what happens if we are both seeing the same patient and don't realize it?

Answer: While this is hypothetical, we don't foresee this happening frequently, and will be addressed on a case by case basis.

44. How is auditing going to happen going forward?

Answer: DPH is developing a plan that will need to be tailored to each provider, as we monitor data, benchmarks and performance targets.

45. Is there flexibility in how we provide you the data?

Answer: Yes. Please outline this in your proposal.

46. Is there room to decrease the data requirements? For example, STI screening is a standard of care why does it need to be reported when it is collected by Medicaid? This is distracting from the other work you are requiring us to do.

Answer: There were initially over 300 variables that were collected under the old HWHBs program model when the NATUS program was in existence. DPH has decreased data burden in response to provider feedback to about 150 variables and it has most recently been decreased further to about 72 data points, 15 of which are the demographics.

47. There is still a data burden and challenges with correct ICD 10 codes; it is still a burden requiring someone to look in the EHR for date STI screening was done and this is not routinely tracked in the same place. If some of these data requirements are already part of standard medical care and not linked to an outcome in relation to the social determinants of health why are we doing it?

Answer: The present data elements requested will be reported and analyzed to show validity of the program and that the program is making an impact.

48. Is there flexibility to change page two of the clinical form and align it with our benchmarks?

Answer: You may certainly add additional details to page 2 of the clinical form.

49. The response to these questions which gets posted on March 11th are critical to how we respond to this RFP. Will there be an expanded time to respond?

Answer: No; questions will be posted March 11th. DPH is aiming to begin HWHBs 2.0 Program via contracts effective July 1, 2019.

50. Is there consideration to phase into this program as this will impact our budget we propose?

Answer: Please outline and define in your proposal a plan and up to three month phased in approach.

51. We get to determine what our budget will be? What is a phased in approach from a budget perspective?

Answer: Please submit an estimated budget that is cost effective in your proposal.

52. We need more than three months to start providing you the data you are requiring. Is this ok? What you are proposing is a big shift in mindset and very data driven. We need to pay someone to pull data out of our EHR and provide you with the data you need, this is a sizeable cost. We would need someone from our IT department help us through this three month process to determine who are the patients for the program and pull that from our EHR, as well as how we could monitor that patient's progress while she is in the program.

Answer: Please outline and define in your proposal a plan and up to three month phased in approach.

53. Are the benchmarks based upon individual patient successes or are they based upon our population and the choice of benchmarks we make?

Answer: This is dependent upon the benchmarks selected, and how you define the measure and performance targets.

54. For the payment structure on page 14, a provider would get $35 per patient if they qualify for program high risk, African American or have two or more risk factors, $10 if high-risk woman, and $25 if from high risk zone, correct?

Answer: Correct. This $35 is a one time payment.

55. What is the high risk zone? The county or the zip code?

Answer: It is the census tract within those zip codes. For example, in Dover 19901, some areas are nice but others are high risk for infant mortality so that is why the census tract matters. The following website may be used as a tool to determine if the patient lives in a high risk census tract:

https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?ref=addr&refresh=t

56. How would we know that a patient lived in that census tract?

Answer: Please use the following website as one example:

https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?ref=addr&refresh=t

57. So we would have to look at census when we enroll patients?

Answer: Yes.

58. Would the state determine if we would get that payment for a high risk zone?

Answer: It is up to the individual provider to verify addresses, request reimbursement and submit monthly invoices.

59. This is a capacity issue and a barrier to have someone go through each patient's address and census tract.

Answer: Providers will have to verify their address through:

https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?ref=addr&refresh=t

60. How do you measure progress of whether or not you met your benchmarks? Individually or collectively?

Answer: Please outline in your proposal the benchmarks selected, and define measure (numerator and denominator), and the performance target. Data will need to be collected individually and tracked over time.

61. Can we select the benchmarks per patient? Or are the benchmarks for our practice? If a woman is pregnant we aren't going to focus on weight loss for her.

Answer: Ideally, we envision proposals from providers that have reviewed current data of their patient population for women of reproductive age, and select the benchmarks that aim to achieve and improve outcomes. For example, if your practice selects health weight, your defined measure will include women in the preconception/interconception period, not pregnant women.

62. If we select the obesity benchmark does it count if we refer her to nutrition or that she loses weight?

Answer: This will need to be defined in your proposal and will be further defined during contract negotiations.

63. You are giving us the flexibility to tell you how we should be reimbursed for the benchmark?

Answer: DPH is looking for providers to develop innovative approaches and strategies to achieve benchmarks and improve outcomes. Therefore, providers will be incentivized for meeting or exceeding benchmarks.

64. When are the benchmark achievements determined?

Answer: The benchmarks will be reviewed monthly and determined by set baseline and performance targets.

65. For some of these women, quarterly is not long enough and how do we get the woman back in?

Answer: In your proposal please outline strategies to engage and re-engage women. DPH will provide TA and support as needed, and this will be a discussion topic at quarterly provider meetings.

66. How would the patient enrollment look in years 2-5 of the contract?

Answer: This will be reviewed and discussed through the quarterly meetings in the first year and addressed during contract negotiations.

67. Would we start with zero for year two again or have a phased in approach for year 2?

Answer: This will be addressed during contract negotiations.

68. If we select substance abuse and screen 100% of our patients in year one and meet that benchmark, does that benchmark go away for year two or does it stay?

Answer: If approved benchmarks in a contract are met or exceeded, new benchmarks and performance targets will need to be defined and implemented.

69. The consent form that is included in the Appendix is written at a grade 16 level; can this be modified?

Answer: This is a sample; we will work with you to develop a consent form that works for your practice.

70. Currently, HWHB supplements vaccines, LARCS and vitamins; will that be included in HWHB 2.0 or is that going away?

Answer: At this time, DPH will need to determine available funding.

71. The LARC issue would be a huge part of the success of this program.

Answer: The Governor's Recommended FY 20 budget and state funds for DE CAN sustainability will need to be approved by the Delaware General Assembly by June 30, 2019. DPH will need to determine available funding for LARCS for HWHBs

72. Is the percentage per benchmark different per provider?

Answer: Yes. This will need to be defined in the proposal.

73. How frequently do we need patients to complete the intake form? 1x per year? Is a "year" a rolling year from the initial enrollment date or is the State fiscal year the definition of a "year" in this program?

Answer: Upon entry, once. The patients and how patients are enrolled in year 2, 3, 4 and 5 will be determined.

74. Does pregnancy status have any bearing on the program or the payments tied to each patient? Does pregnancy status potentially impact the length of time a patient is enrolled in the program?

Answer: No.

75. Do we report and invoice on these women in their enrollment month, or on an ongoing monthly basis?

Answer: Invoices should be processed for one-time base payment in the enrollment month and upon meeting benchmarks.

76. How often are patients required to sign the consent form? And, can it be modified as the literacy level is grade 16? Are both the patient eligibility form and the consent form needed? There is some redundancy. Does these forms need to be saved/kept for audit purposes and available to the program?

Answer: Upon entry into the program. Yes, they can be modified. Yes, please keep on file.

77. We are concerned that the benchmark percentages are too high and unattainable for our patient population. They aren't reasonable benchmarks for us to achieve. Can we propose evidence based goals on our chosen measures that are established by our baseline clinical data?

Answer: Based upon your clinical criteria and expertise, you may propose performance targets and percentages in your proposal.

78. Clarify reporting requirements-i.e. We want to report benchmark, cumulative data on the population, but the RFP suggests that individual patient data is required. Can we give the program access to our EHR for data validation purposes, as opposed to providing individual patient data monthly? If individual data is required, we would like

this to align to our benchmark objectives and want to be cognizant of the difficulties we've previously had acquiring data from our systems.

Answer: You will be required to provide the data in order to get reimbursed. Please describe in your proposal the mechanism for data tracking and reporting.

79. Please define the full population and delineate the high-risk, higher risk, zone qualified populations and how they intersect. ? Are they only African American women and/or with a prior poor birth outcome? Are they only African Americans who are Medicaid eligible? ; There is confusion in the guidance between who qualifies for high risk (the previous HWHB population) vs. higher-risk (African American, prior poor birth outcome or Medicaid) and what parts of the program apply to which population.

Answer: If a women is African American she qualifies. If the woman has a history of poor birth outcome (≤ 2500 grams); premature birth (≤ 37 weeks gestation); infant death (mortality at ≤ 12 months of age); or fetal death/ stillbirth **and / or** 2 or more of the following: chronic disease (diabetes/ prediabetes and high blood pressure); maternal age under 18 or over 25; late entry into prenatal care (after 1st trimester); risk for birth defects; at or below 300% of poverty level; high stress; mental illness; BMI at or above 30.

80. It seems that payment is based on enrollment, not on visits. Is the invoicing tied to individual patient visits? Is there a requirement for in-person visits? If so, what? Do the visits have to be with a licensed independent provider or can they be with an allied health care team member (social service, nursing, nutrition, etc.)? What about telehealth, including phone?

Answer: No. A one-time base payment is based upon enrollment. Please define in your proposal how you will meet or exceed benchmarks and propose strategies that will deliver care to help improve outcomes.

81. Please define "enrollment period."

Answer: A patient that meets the eligibility criteria is "new" and is reimbursed one time. Invoicing is tied to enrollment. Enrollment is the date patient was seen by provider.

82. We believe creating a budget for this program will be challenging with the incentive payment methodology proposed in the RFP. Using examples, can you further explain the payment methodology and how we would attain each of the 4 levels within the payment model?

Answer: One-time base payment of $35 if woman meets eligibility criteria; If the woman is African American or high-risk woman an additional one-time payment of $10. If the woman lives in high risk census track, an additional one-time payment of $25. This is one time reimbursement, per patient, upon enrollment. The Incentive bonus payment structure is dependent upon the benchmark selected and achievement of that benchmark.

83. To what degree does the community health worker need to be involved in the program? At this point, our organization does not have a workforce of CHWs that can be leveraged, and it is unclear if other agencies have the bandwidth to support this program as nearly all CHWs are funded by grants - many that are not aligned with the goals of HWHB. We are concerned that partnering with a CHW workforce will be a difficult deliverable to meet without a designated workforce available.

Answer: The role of the community health worker is very important under the new model, as outlined in the RFP, to address the social determinants of health that impact a woman's well-being. Funding for CHW will be provided by the Division of Public Health who has separate contracts with three agencies to deploy CHWs.

84. If Healthy Women Healthy Baby Zones (HSS 19 018) is intended to create a CHW workforce for this grant opportunity, how will they interact with the contractor/grantee of HWHB 2.0? How much control will the HWHB 2.0 contractor have over their activities?

Answer: The CHW will be supervised by the outside agency for which he/she is employed. Coordination and collaboration will be essential to help meet the needs of women enrolled in the HWHBs program.

85. When we enroll patients, we would like to give them documentation on the program and its benefits. Will HWHB be providing that patient centered education in an appropriate literacy level and in multiple languages?

Answer: There is a consent form that details the program. Changes to that form can be made to work with your clinic and clientele.

86. How do we calculate "increased enrollment" for the target population?

Answer: Based upon data for your program, set a baseline, and performance targets for increasing enrollment of the target population.

87. We are actively engaged participating in the HRSA Maternal & Child funded infant Mortality Preconception CoIIN grant. Will continued participation with this project be a conflict of interest during the RFP bidding period and / or after the awards are presented, should we continue to receive HWHB funding?

Answer: No.

88. Are selected HWHB participants required to attend quarterly cross-providers operating committee meeting in addition to the program coordinator, data and evaluation and management personnel?

Answer: If consumers/HWHBs participants are able to attend operational meetings, consumer input is essential. However, other methods for obtaining consumer input may also be obtained through patient surveys or interviews.

89. Will the operational/provider meeting continue to be held at the Cooper building in Dover, Delaware?

Answer: DPH is working on the details and will welcome feedback on providing different options to make it feasible for all providers throughout the state to participate.

90. If participants are required to attend, will transportation be provided from New Castle County to Dover?

Answer: Yes, participants are required to attend. No, at this time transportation by the state will not be provided.

91. Will all HWHB locations be required to use the PRAPARE assessment tool?

Answer: Providers may propose to use validated or a promising SDOH screening tool of their choice.

92. Are the individual HWHB providers able to select their own tool to measure the SDOH?

Answer: Yes, providers may propose to use validated or a promising SDOH screening tool of their choice.

93. Will the Bundle (ABCD) method of reimbursement continue in HWHB 2.0?

Answer: No.

94. Will the performance benchmarks –incentive payments replace the bundle reimbursements?

Answer: Yes.

95. How will monthly data reporting be calculated, measured and reimbursed?

Answer: Submission of the data points in RFP are a monthly requirement. Obtaining and submission of data is not a separate reimbursable expense.

96. To decrease the percentage of HWHB enrollees documented as being overweight or obese (i.e., reduce BMI): Is this intended for ALL HWHB patients regardless of pregnancy status?

Answer: No.

97. Innovation to address preventive oral healthcare: Is the expectation to provide oral care to patients or is the expectation to improve education awareness and connect patients to resources?

Answer: Detail how you would address this in your proposal.

98. The RFP mentions the development of a work plan after the initial 12 months for the subsequent 4 years. "The plan and budget are to reflect long term sustainability including, but not limited to plans to seek third party reimbursement." Is the intention for awarded sites to begin discussions with third party payers to support this program long term?

Answer: Detail how you would address this in your proposal.

99. Must you reapply each year with new RFP?

Answer: Contracts will be negotiated on an annual basis.

100. How often are you calculating benchmarks?

Answer: Quarterly or as specified in your proposal.