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Optimizing Business Capture for Healthcare



Characteristics of the Winning Medicaid Managed Care Proposal

Characteristics of a Winning Medicaid Managed Care Proposal

White Paper

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Abstract

In those states that conduct procurements for Medicaid managed care, you must deliver a winning technical proposal to secure the business – and if the technical proposal is inadequate, you may not even have your price evaluated. Thus, for managed care organizations that derive some or all of their revenue from publicly-funded healthcare programs such as Medicaid, a high-quality proposal is critical to sustain the revenue stream. Given the cost of preparing a bid – in staff, time, and dollars – any proposal that does not meet the minimum technical score simply wastes corporate resources.

Several recent Medicaid managed care procurements underscore this point – in several cases, there were health plans that did not pass the technical proposal evaluation, and hence lost business. Yet, by examining aspects of several Requests For Proposal (RFP) and combining that with experience in winning prior business in the public-sector health marketplace, we can identify characteristics that raise the odds of winning. These characteristics include careful conformance to the specific requirements of the RFP, support for achieving the state's objectives, and careful delivery of the message to simplify the work of the proposal evaluator, among others.

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Introduction

With recent contract awards for the Texas and Georgia Medicaid Managed Care Programs (July 2005), it is apparent that there are big wins and losses in these competitions. In fact, when the Georgia program results were posted, several health plans did not meet the technical threshold needed to proceed to pricing evaluation.¹ While not all states post such information, individual bidders know the answer: some walked away with business; others left empty-handed. Given the time, expense, and stress associated with developing a proposal, those who lost are perhaps saying “never again”...or wondering what went wrong so they can avoid these mistakes for the future.

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Optimetra, Inc. worked on technical proposals that won several regions in both the Texas STAR and CHIP programs as well as several regions in the Georgia Cares Program. We also have developed winning proposals in the Florida Healthy Kids SCHIP program and contributed to others selected for contract negotiations in Indiana and New Mexico, as well as winning TRICARE and commercial proposals. While no one can have perfect insight into the decisions made by evaluators – each procurement is different – successful technical proposals share six key characteristics that help increase evaluation scores and improve the odds that your proposal will win business. These are as follows:

1. Demonstrate how you will meet *all* of the requirements
2. Simplify life for the evaluators
3. Deliver a competitive network
4. Show how you will pay providers correctly and on time
5. Understand and address the state’s objectives
6. Offer innovative solutions with demonstrated results

While we do not address pricing here, it is important, of course. In some cases, a state will provide the rates; your actuarial consultant will need to evaluate those rates, and your management team will need to decide whether those rates are acceptable. If you are bidding in a state that asks you to quote rates, your actuarial consultants and management team will need to create rates that can be certified as actuarially sound and enable your health plan to cover its administrative costs and margin requirements. This can be tricky as well – in the recent Georgia Cares Program procurement, pricing only became a factor after health plans achieved the technical threshold. Rates outside Georgia’s independent pricing range (not revealed to bidders) were penalized in scoring. In other states, pricing may be constrained by particular rules in the RFP – for example, the medical loss ratio (MLR) may be no less than 85% (or some other figure) or the maximum profit may be limited.

¹ See http://ssl.doas.state.ga.us/PRSapp/PR_bid_notice.jsp?bid_op=054190041900-001-0000000027.

Demonstrate How You Will Meet *All* of the Requirements

Failing to provide complete and detailed responses to each of the requirements specified in the RFP is one of the most common reasons why health plans are eliminated from the “short list” by evaluators. It is the easiest way for the evaluator to discriminate. Suppose the RFP requires you to submit a draft quality management program description and annual workplan with the proposal, but you submit neither. Points off the evaluation; or, if the evaluation is pass/fail, then fail.

Established commercial health plans new to the government marketplace often make the mistake of ignoring the requirements. Instead, they often try to show strength in size and experience to answer every question, rather than specifically addressing the problem. For example, the RFP might require you to provide a software system to conduct health risk assessments that cover a particular set of criteria. Table 1 (see attachment at the end of this white paper) shows some examples of how you might respond to such a requirement – and what *not* to do.

In federal procurements, bidders sometimes have the opportunity to clarify responses by answering questions that evaluators have posed about the proposal.

...break down every requirement into its component parts; make sure you respond to every requirement; provide a complete response to each requirement.

State procurements sometimes offer this chance to correct and expand your answers, but not always – it is better to ensure your response is correct and complete upon submission. So – break down every requirement into its component parts; make sure you respond to every requirement; provide a complete response to each requirement. To help you think through this, here are a few questions (based on the journalistic “who, what, when, where, why, how”):

- ◆ Who will perform the process? (Management responsibility; job titles)
- ◆ What will be done?
- ◆ What experience do you have in performing this task? (Markets, number of years, number of members, etc.)
- ◆ When is it done? Are different parts done at different times over the course of the entire process? Are there specific reasons for the timing?
- ◆ Where is it done? (For example, is the work done centrally, regionally, or locally, and why? Do you have it done by a subcontracted vendor instead; if so, why?)
- ◆ Why have you made the choices to perform the process in this way? (This is the place to demonstrate insight into the process – in particular, familiarity with local provider patterns of practice or health or cultural issues specific to the Medicaid population.)
- ◆ How will you do the work? (This is often the most overlooked question, and yet the most important one to answer completely – specify the work process, systems and people involved, and so on. A complete description here demonstrates to the evaluators that you fully understand what is required to do the work.)

Simplify Life for the Evaluators

Many proposals simply make evaluation difficult. They are disorganized – either in their structure or in the thinking that went into the writing; they make it hard to find information; or they are filled with hyperbole, clichés, jargon, or fluff that bore the evaluator and cause him or her to discount your proposal's technical score.

A forthcoming article from Optimetra will address this problem in much greater detail. The key ideas are as follows. Check back at Optimetra's web site (<http://www.optimetra.com>) for further information:

Rule 1: Simplify Accessibility. This includes doing things that help make it easier for evaluators to find the information they need. Things you can do to help simplify accessibility include:

- ◆ Taking a proactive approach to overall document design, providing a logical structure and an engaging visual design.
- ◆ Considering physical packaging, including good choices of binders and volume divisions and using divider tabs effectively
- ◆ Providing good access tools, including a comprehensive table of contents (and section table of contents when necessary), a complete index, and complete cross-references.

Rule 2: Clarify Meaning. This includes doing things that succinctly and completely convey your proposed solution to the evaluator in an easily-understandable way. Things you can do to help clarify meaning include:

- ◆ Editing aggressively, but clearly, to help focus meaning and remove unnecessary baggage.
- ◆ Editing in multiple passes to simplify the editing process and to ensure that every problem of a given type is addressed throughout the document.
- ◆ Avoiding the passive voice to clarify the meaning of sentences and save words.
- ◆ Reducing sentence length to get to the point, and remove the need for evaluators to struggle through long, wandering, confusing sentences.
- ◆ Limiting paragraphs to only one topic, to avoid wandering between ideas and consequently confusing the discussion.
- ◆ Throwing away non-contributing material – if it does not add to the discussion, why bring it up?
- ◆ Standardizing usage, to remove confusion about the objects you refer to.

Deliver a Competitive Network

Each state sets different standards for provider access. And, access is a state program objective that appears with regularity across Medicaid managed care RFPs. So – it is critical that you deliver a network that not only meets the minimum requirements, but exceeds those requirements wherever possible. (In fact, the 2004 Michigan Medicaid managed care program RFP scored nearly all of the technical proposal on a pass/fail basis – except for the provider network, which had the bulk of evaluation points.)

...it is critical that you deliver a network that not only meets the minimum requirements, but exceeds those requirements wherever possible.

Balancing this against the need to focus the network – to drive greater volume to fewer providers in exchange for better reimbursement schedules – is not a trivial task. Neither is the problem of handling missing specialties and institutional services, particularly in rural areas. Priority, though, must go to completeness and network coverage – without the contract, the question of focusing the network is moot.

Questions you will need to address when working on your network proposal include the following:

- ◆ Who sets the network standards for the contract? Is it the state Medicaid agency or the state department responsible for regulating HMOs and insurance companies? If the standards differ, is there a way to have them reconciled to simplify compliance? Are the standards realistic given the availability of providers for contracting? If not, will the state consider changes to the standards? All of the questions about standards must usually be addressed through the formal question and answer process established by the procurement contracting officer; it's best to do this as soon as possible so your network team knows what they must achieve.
- ◆ Can you meet the network standards in all of the desired service areas?
- ◆ Is there simply a lack of specialty or institutional providers in a particular service area? If so, what contingency plans will you propose to address these deficiencies?
- ◆ How will you help ensure the availability of providers who are contracted in your network? What actions will you take if provider availability is insufficient?
- ◆ What data sources will you use to prepare the necessary provider data tables and geographical maps for submission with the proposal? Do all of the data sources reconcile for all provider types across all service areas? If there are discrepancies, you will need to find and correct them to ensure your submissions are correct.
- ◆ Must you also submit your network to the state department of insurance for license approval in that service area? If so, how will you ensure that your data for each submission type reconciles, and that any differences between the two submissions can be clearly explained?

Show How You Will Pay Providers Correctly and On Time

While not every RFP explicitly identifies timeliness of claims payment as a state objective, we know that this is a serious issue for every state, whether in Medicaid managed care or the state's fiscal intermediary and Medicaid Management Information Systems (MMIS) contracts. State agencies are overwhelmed with complaints about late or incorrect provider payments. See the following articles for examples:

- ◆ Michigan; report on Medicaid timely claims payment:
http://www.michigan.gov/documents/cis_ofis_medi_pmt_25601_7.pdf
- ◆ Louisiana; Stanocola Medical Center bankruptcy:
http://www.medicaldistribution.com/daile/daile_073001/daile_73020011049097.htm
- ◆ Nevada; glitch delays Medicaid payments:
http://www.reviewjournal.com/lvrj_home/2004/Jan-10-Sat-2004/news/22968411.html
- ◆ North Carolina; Medicaid overpayments to hospitals:
<http://www.newsobserver.com/business/story/2609909p-9044952c.html>
- ◆ Georgia; ongoing Medicaid payment problems:
http://bg.homecaremag.com/ar/medical_georgia_payment_problems/index.htm

Though the claims payment and information technology section of most Medicaid managed care RFPs is usually lighter in requirements than other sections, it is your chance to demonstrate your ability to address this problem that is a “hot button” for state regulators. Show how your system and processes:

- ◆ Are configured and tested to produce accurate payment results for all benefit packages and all provider contract types
- ◆ Reduce cycle time through the use of innovative technology and processes
- ◆ Ensure only correct payments are sent through careful auditing and quality control
- ◆ Correct errors through continuous quality improvement programs
- ◆ Work to quickly resolve payment disputes with providers

Address the State’s Objectives

Most states clearly define their objectives for the procurement in the RFP. Examples from several procurements from 2002 through 2005 are shown in Table 2 below.

Table 2. State Objectives in Recent Medicaid Managed Care Procurements

State	RFP	Objectives
Florida	FHK Corporation RFP (March 2003)	<ul style="list-style-type: none"> ▪ Encourage appropriate use of preventive health care and appropriate service utilization ▪ Provide comprehensive health insurance coverage to uninsured children ▪ Establish medical home for each enrollee
Georgia	DCH RFP 41900-001-0000000027 (January 2005)	<ul style="list-style-type: none"> ▪ Improve the health care status of the Member population ▪ Establish a “Provider Home” for Members through its use of assigned Primary Care Providers (PCPs) ▪ Establish a climate of contractual accountability among the state, the care management organizations and the health care providers ▪ Slow the rate of expenditure growth in the Medicaid program ▪ Expand and strengthen a sense of Member responsibility that leads to more appropriate utilization of the health care system.
Michigan	DCH ITB 07114001168 (March 2004)	<ul style="list-style-type: none"> ▪ Access to primary and preventive care ▪ Establish a “medical home” and the coordination of all necessary health care services ▪ Provision of high quality medical care that provides continuity of care and is appropriate for the individual ▪ Operation of a health care delivery system that enables Michigan to control and predict the cost of medical care for the Medicaid population.
New Mexico	HSD Solicitation 05-8000-05 (November 2004)	<p>The primary goal of this procurement is to[:]</p> <ul style="list-style-type: none"> ▪ improve the health of New Mexico Medicaid members by expanding health care choices, ▪ improving access to quality health care, increasing coordination of care, ▪ improving health outcomes, and ▪ decreasing the rate of growth in Medicaid program expenditures.
Pennsylvania	OMAP RFP 13-02 for the Healthchoices Northwest and Southwest programs (November 2002)	<p>The goals of the HC-NW and HC-SW Programs are to improve the accessibility, continuity and quality of health services for Pennsylvania’s MA population, while stabilizing expenditures. The Department seeks to purchase services from a health plan that assures comprehensive treatment for persons, especially children and pregnant women, who may need access to health care.</p> <p>The Department also recognizes its obligations to assure accessible, quality health care for persons with special needs for whom a comprehensive network of quality providers is so important.</p>

State	RFP	Objectives
Texas	HHSC RFP 529-04-272 (July 2004)	<ul style="list-style-type: none"> ▪ Network adequacy and access to care ▪ Timeliness of claims payment ▪ Timeliness with which prenatal care is initiated ▪ Behavioral health ▪ Delivery of health care to diverse populations ▪ Disease management requirements ▪ Expansion of STAR+PLUS into additional CSAs

It is likely that the state agency, working with legislative committees and RFP consultants, devoted substantial thought and effort to the listed objectives. Notice, too, the commonality between objectives for the states:

- ◆ Providing sufficient access to network providers
- ◆ Creating a “medical home” or “provider home” for the member
- ◆ Improving members’ health status
- ◆ Controlling cost growth for the Medicaid program
- ◆ Encouraging appropriate use of medical care

Your win themes – the core benefits that you argue are supported by your processes, people, systems, technologies, and initiatives – must directly support state’s objectives. So, if you have a program that directly addresses the needs of a specific subset of the population – for example, patients with multiple chronic diseases – you should demonstrate how:

- ◆ You have sufficient providers to make it easy for the population to enter the program in all service areas
- ◆ Those providers have specific expertise in treating the conditions covered under the program and will create a repeatable, sustainable environment and a personal relationship with the member and his or her family
- ◆ The program will achieve improved health outcomes for the selected population subset (show statistically-significant improvements in reduced ER visits and so on)
- ◆ Overall comprehensive costs are lowered for the population subset on a year-over-year basis
- ◆ Members of the program have more effective use of medical care options, with fewer choices of high-intensity care settings such as ER visits or inpatient care

Support your arguments – use quotes, statistics (including comparison tables or charts), case studies, and personal stories (appropriately redacted to prevent any release of individually-identifiable health information). Saying “we have shown an 8.7% decrease in cost for the selected population of 75 individuals on a year-over-year basis” is far more meaningful than simply saying “Our program helps control costs for this population.”

Offer Innovative Solutions with Demonstrated Results

If the playing field is tilted toward incumbents – who have been performing the business adequately according to the state’s existing requirements – the outlook for your proposal to succeed can be decidedly bleaker. You are working against inertia – so long as the existing plans have reasonable customer satisfaction, do not generate too many complaints to the state, are financially solvent, and otherwise meet state requirements, they will likely be selected to continue.

There are opportunities to unseat such competitors, though. Can your health plan offer innovative, proven solutions to help achieve the state’s objectives – and in particular, to improve health outcomes for the Medicaid population while either controlling cost growth or lowering overall costs? If you are offering something truly unique and you can demonstrate statistically-significant advantages, then evaluators may take the opportunity to replace a lackluster health plan with one they believe can truly make a difference.

Make sure the solution is really unique, and that you have proven results, before making the claims.

Again – it has to be innovative, and demonstrably better. On the first, be careful about taking your health plan’s press too seriously. It seems relatively common to encounter a health plan that says “oh yes, our secret weapon is X” – only to find, via a Google™ search, five other health plans that offer X and have spoken about it at national conferences. Make sure the solution is really unique, and that you have proven results, before making the claims.

Conclusions

Health plan management will want the substantial effort invested in a proposal development project to bear fruit – win the contract! Yet, health plans regularly lost business in procurements through inadequate attention to key proposal characteristics that will help maximize their technical score.

- ◆ *First*, by demonstrating that you meet all of the requirements, you can help the evaluator award your proposal the maximum number of points, and minimize loss of for areas in which you do not presently have a solution, but will develop one for the contract.
- ◆ *Second*, by simplifying life for the evaluator through simplified accessibility and enhanced clarity of your proposal, you make it easy for them to find the description of the solution to the problems presented in the RFP. More important, you make it easy to understand your solutions – instead of wondering “what problem are they trying to solve?”
- ◆ *Third*, by delivering a competitive network, you address a question common to every public-sector healthcare program – that of providing easy access and high availability of the doctors that the members want to see.

- ◆ *Fourth*, by showing how you will pay providers correctly and on time, you address a critical “hot button” for state agencies and providers alike.
- ◆ *Fifth*, by understanding and addressing the state’s objectives for the procurement, you demonstrate that you are attuned to the needs of the state and those of the Medicaid population you will serve during the course of the contract.
- ◆ *Sixth*, by offering innovative solutions with demonstrated results, you set yourself apart from your competitors by offering unique combinations of program features and statistically-significant improvements in health outcomes and controlled costs.

Adherence to all of these characteristics does not guarantee that you will win the business. Pricing, as determined through a combination of professional actuarial evaluation and management responsibility for fiscal soundness of the health plan, is still critical. But, by maximizing your technical proposal score, you raise the chance that your proposal will reach the pricing evaluation stage, and increase the probability of winning a substantial revenue source for your managed care organization.

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About Optimetra

Founded in 1997, Optimetra, Inc. is a nationwide leader in business capture management and implementation solutions focused on serving the needs of public sector and commercial healthcare companies. Customers enhance their competitive advantage by calling upon Optimetra to provide healthcare proposal expertise and implementation leadership. Optimetra leverages B&P budgets by conducting early and intelligent RFP analysis; quickly and effectively guiding proposal teams to consensus throughout the proposal development process; and providing seasoned proposal developers with many years of healthcare business development experience. Using project management tools and controls created expressly for healthcare organizations, our team of implementation specialists helps you achieve efficient, profitable, and sustainable integration for new healthcare business.

Optimetra has worked on winning implementation plans for several recent winning proposals, as well as for various Medicaid, CMS, and TRICARE contracts. To find out more about how Optimetra can help you win and successfully implement new business, call or e-mail us, or visit <http://www.optimetra.com>.

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About the Author

Dave Kumpf is President and founder of Optimetra. He is also a key consultant for the firm, focusing on public sector healthcare business capture, including RFP analysis, proposal strategy development, and project management for proposals and new business implementation. Dave's current and past engagements include:

- ◆ Medicaid managed care proposal leadership and development
- ◆ TRICARE proposal leadership and development
- ◆ MMIS proposal development
- ◆ Managing complex acquisition integration
- ◆ Implementing new managed care business
- ◆ Development and deployment of healthcare project management methodologies & training

Dave is responsible for all aspects of Optimetra's continued growth and key decision making, including: corporate strategy, client relationship building, and hiring decisions. Dave is a certified project manager (PMP) and newly-appointed Director of Development for the Project Management Institute Healthcare Specific Interest Group. He is also an active member of the Association of Proposal Management Professionals. Prior to leading Optimetra, Dave held positions as Director of Process Engineering and Director of Business Projects at Foundation Health Systems, Inc. He was also President and co-founder of Lexicon Systems, Inc., a consulting firm that focused on engagements in information development, software engineering, and project management.

Table 1. Different Ways to Approach Responses to Requirements

What you have	What you write	What will probably happen in evaluation
<p>You do not have such a system, but have developed custom software systems for your commercial business.</p>	<p>“Because we have developed custom software systems of comparable complexity for our commercial software business, we are confident that we can accomplish this task. XYZ Plan takes pride in its use of state-of-the-art software development methods and 38 programmers with Ph.D.s in computer science.”</p>	<p>It is likely that you will receive few points, if any. Or, a lot of questions during the government’s clarification phase. Your proposal does not demonstrate that you have a solution for the problem.</p>
<p>Your proposal provides:</p> <ul style="list-style-type: none"> ▪ flowcharts of your software development methodology ▪ discussions of three similar projects with metrics on schedule, cost, and test results ▪ identification of the leadership and staffing assigned to this project ▪ narrative discussion of how you will approach this particular project ▪ insight into particular issues with the process of conducting health risk assessments on the Medicaid population and how you can address these problems through either the software itself, process design, training, or all of these ▪ detailed workplan for implementation 	<p>You will probably receive at least some of the evaluation points for this requirement, if not most. You have demonstrated that while you do not have a specific solution at the moment, you have an idea of how to construct one and a very high probability of delivering. In addition, you have indicated your familiarity with the specific needs of the population and the contract. (It is possible that you may only receive a few points if every other bidder already has a solution in place; nevertheless, this approach is still strong if you do not otherwise have a solution.)</p>	

What you have	What you write	What will probably happen in evaluation
<p>You do not have such a solution, but plan to acquire one from an external source.</p>	<p>“We plan to acquire a solution from ABC Health Assessment Systems, who has an extensive track record in this industry.”</p>	<p>It depends. Are you just acquiring the software and expecting your people to simply start using it? Or is ABC Health Assessment Systems providing the full functionality and shipping data to you from the assessments? You may only receive partial points if the evaluators cannot clearly see how the acquired solution will fit cleanly into your systems and processes.</p>
	<p>Your proposal provides:</p> <ul style="list-style-type: none"> ▪ Complete details on what you will acquire from the external vendor – does it include just the software, or installation and configuration, training, and process design? ▪ Description of the vendor’s experience in providing these solutions, and (ideally) demonstration that the solution is specifically targeted at the Medicaid marketplace. ▪ Explanation of the responsibilities the external vendor will have on an ongoing basis – do they perform the assessments and provide data to you? If they provide the assessments, how do you smooth the handoff from the health plan to the vendor to provide the assessments? Does the vendor interpret the results? ▪ How will you follow up on the assessment results? ▪ How will you address any problems that arise in the assessment, e.g. member complaints re intrusiveness of assessments, flawed results, etc? 	<p>If the solution is Medicaid-targeted and you can demonstrate a strong vendor track record and seamless integration of the solution, you should usually receive most or all of the evaluation points.</p>

What you have	What you write	What will probably happen in evaluation
<p>You have a solution but it is specifically targeted at other business; it will have to be adapted to the needs of this contract.</p>	<p>See the first alternative above – as above, if you clearly describe what you will do to adapt the solution to the specific needs of the contract, you are likely to do well in evaluation; if you simply claim that it will be “great” then chances of scoring well are slim at best.</p>	<p>Risky – if the evaluator is completely otherwise familiar with your performance in the other states on such assessments, you might score well. But you have not really demonstrated, beyond some claims about using the system elsewhere, that you understand the issues with performing health risk assessments on this population.</p>
<p>You have a solution that specifically meets the needs of the contract.</p>	<p>“Our SuperAssess Health System has been used in three states with 200,000 Medicaid members to conduct assessments just like the ones used for this contract.”</p>	<p>You should receive most or all of the evaluation points, if your solution is described well and the evaluator cannot find significant issues with your approach.</p>
<p>Your proposal provides:</p> <ul style="list-style-type: none"> ▪ information about the capabilities of the system, including architecture, data elements captured, overview of the system’s use in practice ▪ information on how the system is integrated into your business processes, including who uses it, how handoffs to and from assessment occur, and so on ▪ discussion of evolution of the system ▪ experience in using the system, number of states covered, number of members covered, years in use ▪ insights into particular health risk issues for this population ▪ how you follow-up to particular health risk issues 		