State of Vermont
Department of Vermont Health Access
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Agency of Human Services
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REQUEST FOR INFORMATION

REGARDING

PILOT PROTOTYPES FOR ALTERNATIVE SYSTEMIC APPROACHES TO MANAGEMENT OF CHRONIC PAIN

ISSUE DATE: July 26, 2018

RFI RESPONSE DUE DATE: August 3, 2018 at 3:00 p.m.

RFI RESPONSES MUST BE RECEIVED AT: NOB 1 South, 280 State Dr., Waterbury, VT 05671-1010 for paper responses, or AHS.DVHABlueprintforHealthDocumentSubmission@Vermont.gov for electronic responses.

RFI RESPONSE OPENING: Responses will be opened and reviewed on a rolling basis as received.

PLEASE BE ADVISED THAT ALL NOTIFICATIONS, RELEASES, AND AMENDMENTS ASSOCIATED WITH THIS RFI WILL BE POSTED AT:

http://blueprintforhealth.vermont.gov

THE STATE WILL MAKE NO ATTEMPT TO CONTACT POTENTIAL RESPONDENTS WITH UPDATED INFORMATION. IT IS THE RESPONSIBILITY OF EACH RESPONDENT TO PERIODICALLY CHECK http://blueprintforhealth.vermont.gov **FOR ANY AND ALL NOTIFICATIONS, RELEASES AND AMENDMENTS ASSOCIATED WITH THIS RFI.**

BLUEPRINT CONTACT: **Beth Tanzman**
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FAX: **(802) 241-0269**

1. NOTICES

This Request for Information (RFI) is issued by the Department of Vermont Health Access (DVHA) and Vermont Blueprint for Health (Blueprint) to gather input and obtain information and cost estimates to support its objective of developing pilot prototypes for alternative systemic approaches to management of chronic pain.

1.1 Liability

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY. This RFI is issued solely for information and planning purposes – it does not constitute a Request for Proposal (RFP) or a promise to issue an RFP in the future. This request for information does not commit the State to contract for any materials or service whatsoever. Further, the State is not at this time seeking proposals and will not accept unsolicited proposals. Respondents are advised that the State will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future RFP, if any is issued.

1.2 Confidentiality

The Blueprint retains the right to promote transparency and to place this RFI into the public domain, and to make a copy of the RFI available as a provision of the Vermont access to public records laws. Please do not include any information in your RFI response that is confidential or proprietary, as the Blueprint assumes no responsibility for excluding information in response to records requests. Any request for information made by a third party will be examined in light of the exemptions provided in the Vermont access to public records laws.

The solicitation of this RFI does not commit the Blueprint or the State of Vermont to award a contract. This RFI is for information gathering purposes only and no respondent will be selected, pre-qualified, or exempted based upon their RFI participation.

2. INTRODUCTION

Governor Phil Scott has demonstrated his commitment to confronting the Opioid epidemic in Vermont. In his testimony before Congress, the Governor outlined Vermont's focus on the four legs of the stool: Prevention, Recovery, Treatment, and Enforcement and cited the federal government for its continued partnership with the State to identify and implement innovative models for addressing substance dependency at multiple points along the continuum. Specifically, the Vermont All-Payer Accountable Care Organization Model Agreement provides flexibility for the State of Vermont to include Medicare in potential solutions to this crisis and in return expects that the State will reduce the drug overdose deaths.

The Department of Vermont Health Access and the Blueprint for Health have convened a working group of payers and clinical leaders to help design pilot prototypes for more integrated and comprehensive approaches to the management of pain. This Request for Information (RFI) will help inform the development of a Request for Proposals (RFP) for pilot tests of new service arrangements. These arrangements may include integration of complementary and alternative modalities, alternative payment approaches, enhanced primary care services, specialty clinics and transdisciplinary consulting teams. Pending the information gathered from this RFI, DVHA anticipates posting a Request for Pilot Proposals in late summer. Proposals for the pilot programs will be restricted to currently enrolled Vermont Medicaid providers.

3. PURPOSE

The Department of Vermont Health Access seeks information from existing Vermont Medicaid service providers with which to develop alternative approaches to the management of chronic pain. The objective is to solicit feedback about

a draft framework (described herein) to pilot new services that provide coordinated specialists, complementary and alternative treatment modalities (CAMs), and ongoing enhanced primary care for Medicaid Members experiencing complex pain conditions for three months or longer duration. Development and testing of pilot programs will help identify the services arrangements that:

- have the greatest impact on beneficiary outcomes (decreased impact of pain on psychological and physical function and increased self- efficacy)
- are feasibly replicable and scalable for statewide implementation
- have the most impact on reducing total cost of care to help assure funding sustainability over time

DVHA is seeking information about payment-supported approaches that will align across payers.

The State is seeking feedback on the information in this RFI and will consider any information, including partial responses, received in response to this RFI. If the State moves forward in the development of an RFP, the RFP process will be open to all respondents regardless of their decision to participate in this RFI.

4. WHY (consider changing our approach to treatment of chronic pain?)

Current services and reimbursement favor other interventions over CAMs

Current service provision, benefits, and reimbursement patterns favor medical, pharmacological, and surgical treatments for pain; however, there is growing evidence demonstrating the importance and effectiveness of cognitive behavioral therapy, exercise and physical reconditioning, nutrition, and complementary alternative modalities as first line interventions for pain management[1]. The draft pilot framework outlined in this Request for Information is based on the hypothesis that non-pharmacological and non-surgical treatments for chronic pain can serve as the foundation for effective treatment. Figure 1 sets forth a hierarchy of interventions where the base of the pyramid represents the least expensive and least invasive therapeutic options, all of which have efficacy in addressing chronic pain. As one ascends through the top half of the pyramid, the interventions increase in cost and sometimes carry risk of adverse outcomes to the patient – potentially without a corresponding increase in efficacy.

[1] CAMs includes: chiropractic, acupuncture, yoga, massage, Tai Chi, Feldenkrais, mindfulness & meditation. Psychological treatments include cognitive behavioral therapy (CBT) and trauma-specific treatment.

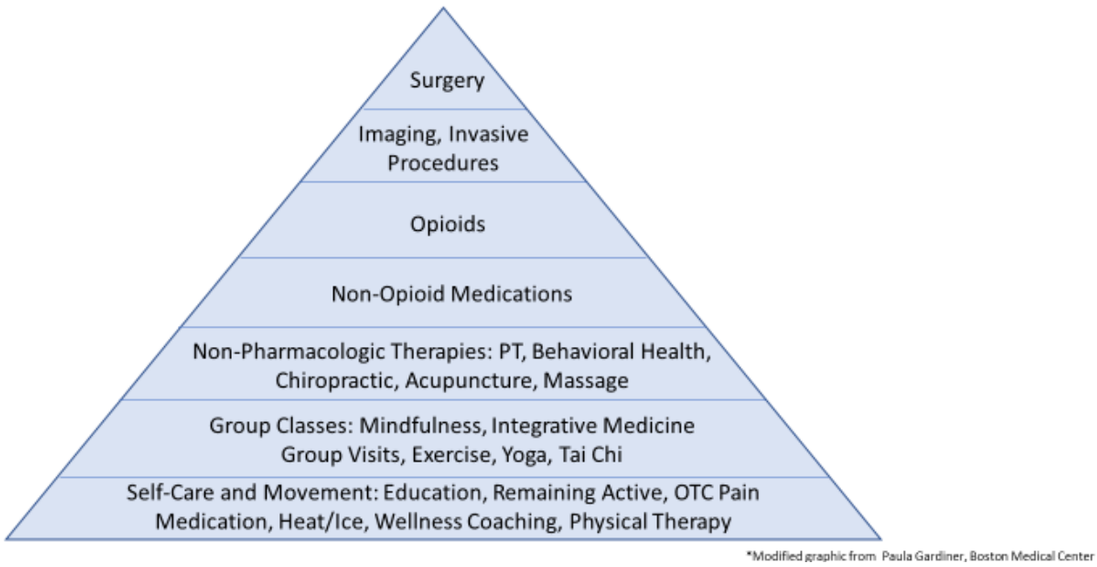


Figure 1 –

While counseling and physical therapy are generally covered services, supports such as CAMs and exercise are not part of Vermont's Medicaid health plan benefit. The result is that medical procedures and pharmacological treatment (especially with opioids) may be prescribed more and are relatively more accessible to Medicaid Members than approaches involving exercise and CAMs due to cost/reimbursement rates and ease of use. Medicaid Members may also experience greater access issues due to out-of-pocket costs for CAMs.

CAMs are not coordinated in a way that would make them accessible and useful for members.

Individuals struggling with chronic pain often have complex clinical needs involving overlapping physical health, mental health, and substance use conditions. However, psychological, health, physical rehabilitation, and CAM services are rarely offered in a coordinated or integrated fashion. This lack of coordination can impact the success of each element of care and make it more difficult for patients to get the care they need.

Providers also face significant challenges and barriers to offering patients appropriate and successful care for chronic pain conditions. The care management and panel management services required to organize care across disciplines are not adequately reimbursed. The time needed for transdisciplinary teams to meet, formulate treatment plans, and monitor progress is also not sufficiently supported within payment systems.

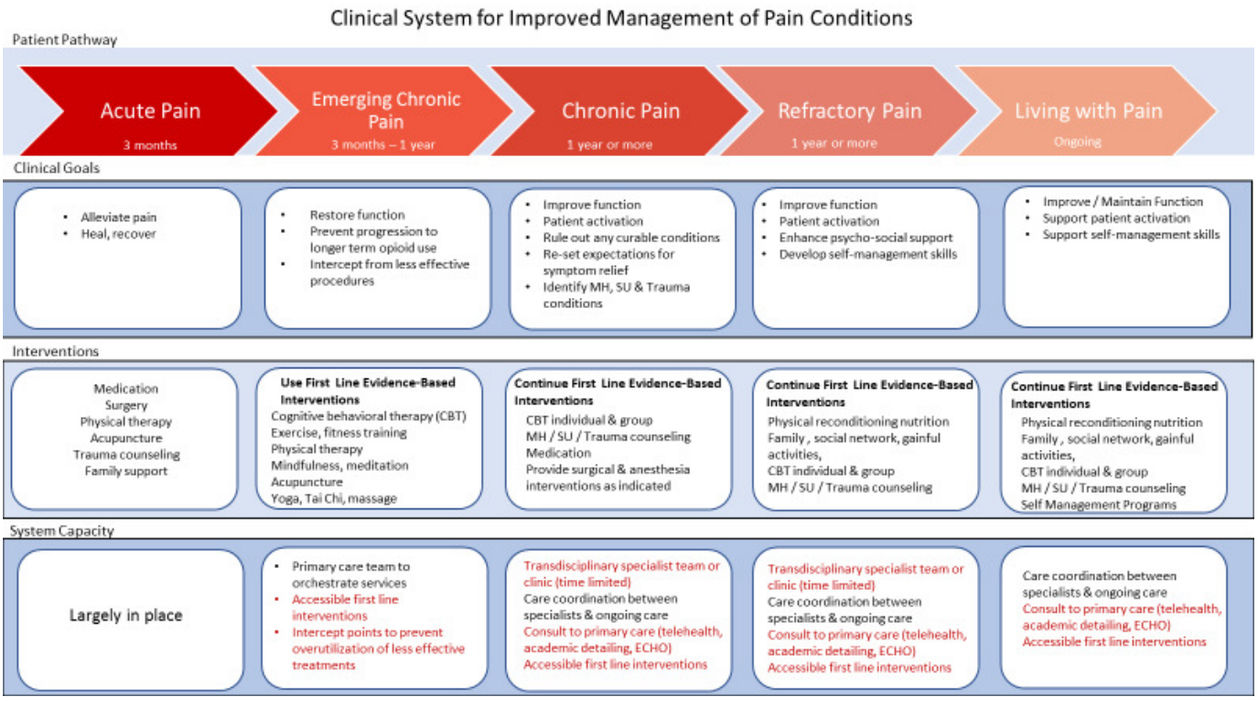
Other challenges to changing the current treatment paradigm exist.

While the evidence is growing that mental health, physical conditioning, and CAMs are central to the successful restoration of functioning for patients with complex pain conditions, the practice of these disciplines may not always entail rigorous standards of care and consistency that health plans require. Finally, while there is consensus that changes in pain management practices are needed in the face of the current opioid epidemic, we may be limiting treatment options (such as longer-term use of opioids) more rapidly than we are adding new capacity for other effective approaches.

5. HOW (might we approach treatment of chronic pain differently?)

Transdisciplinary teams delivering integrated allopathic, psychological, and CAMs services is the emerging standard of care for the management of patients with complex conditions and chronic pain. As one of Vermont's largest payers' the Medicaid program can help stimulate the development of new health care system capacity to support interdisciplinary teams, clinics, and enhanced primary care services by issuing a Request for Information to help develop a framework to test prototypes. At this time, information is being gathered to better understand health system infrastructure in place in Vermont that could be supplemented to enhance the desired systemic approach to management of chronic pain in the state.

In order to effectively address clinical goals for management of pain conditions system capacity needs to be created for patients and their providers. This RFI aims to help inform the development of potential pilot programs that not only provide accessible first line interventions and access to specialized time-limited transdisciplinary pain care, but also create system capacity that can effectively support patients living with pain, their family and support systems, and their primary care providers. Figure 2 below describes the clinical goals, interventions, and system capacity Medicaid seeks to support and/or enhance across the spectrum of pain conditions. The items in red font indicate system capacity that is generally not in place in Vermont. This RFI seeks information and recommendations about how to develop the missing system capacities.



6. WHAT (information we seek)

DVHA seeks information to help develop service designs that can be pilot tested. Such service designs would incorporate integrated approaches to management of complex pain and behavioral health conditions. DVHA seeks information about an approach employing these fundamental components:

I. Convening an interdisciplinary team of pain specialists (a team with chronic pain expertise that serves the Clinic and consults to the Primary Care teams on complex cases)

II. Implementing interdisciplinary intensive and time-limited clinic-based services (similar to a "HUB" in Vermont's Medication Assisted Treatment model)

III. Implementing enhanced primary care services providing ongoing medical, psychological, and CAMs services (similar to a "SPOKE" in Vermont's Medication Assisted Treatment model)

DVHA seeks information about how service designs could link all three components, test alternative payment models, and evaluate program outcomes. It is expected that more than one prototype may be developed and tested, reflecting local opportunities and allowing for evaluation of more than one approach.

Additionally, we seek information about how service designs could incorporate the following sub-components:

i. Engagement of the family system – provision of education and support services for the patient's primary support provider, when identified

ii. Identification of and allowance for addressing barriers to care - including transportation.

iii. Optimization of opiate medication management and safety for patients.

iv. Information about the potential for the use of buprenorphine-naloxone for patients with chronic pain and opioid use disorder is also welcome.

Finally, we seek information about how to design pilots that provide strong linkages with addiction treatment resources and which articulate an approach to working with patients who are in active treatment for a substance use disorder.

The information gained from this RFI will be used to help develop a future Request for Proposals that addresses all three main components and the four sub-components. As integrative and comprehensive services to address chronic pain are at a prototype phase in Vermont, any partners participating in future pilots will work with the State to design the program components, staffing, and workflows consistent with the program framework, and will be expected to participate in a state-wide learning community to accelerate the spread of innovation and to support practice transformation.

7. DESIRED OUTCOMES; MEASUREMENT

DVHA seeks information to help develop a measurement approach to evaluate the effectiveness of future pilot service tests. The following outcomes are under consideration, and we seek information about these and other appropriate measures and the feasibility of collecting data across practice settings.

- Impact of pain on psychological and physical function
- Self-efficacy and sense of personal agency
- Patient and family pain management knowledge, skills, and attitudes
- Self/family employed management strategies
- Emergency Department, Surgical, Pharmaceutical, and Imaging Studies utilization
- Reduction in opioid use
- CAM utilization
- Completion rate of treatment programs

- Fidelity to selected interventions
- Care coordination
- Patient satisfaction
- CAM provider satisfaction
- Primary Care Provider satisfaction

8. PROTOTYPE PILOT FRAMEWORK

This initial framework was developed based on a series of key informant interviews, subject matter expert input, and a review of the literature. Please provide commentary as to the comprehensiveness, appropriateness and feasibility of developing pilot programs in Vermont using this framework. Information gathered to date indicates that it is important for each component to be interdisciplinary, including CAMs, and to incorporate approaches specialized for the management of pain and co-occurring conditions. This initial framework also reflects an approach that includes both intensive time-limited services and ongoing care to maintain wellness. Finally, the framework includes specialist teams available to provide ongoing consultation and mentoring to primary care teams. The framework reflects a consensus of information gathered to date; however, we seek additional information about other possible framework elements or approaches. Ultimately DVHA is looking for programs that can be replicated and scaled to meet statewide need and that can be part of an integrated health system across all payers.

Blueprint intends to use the information it gathers in relation to the program framework to develop a definitive Request for Pilot Proposal (RFP). Blueprint envisions that such an RFP, if issued, would request that potential bidders address the requirements in sections I, II, and III below. To that end, Blueprint seeks information and feedback regarding the following.

I. Identification of the Patient Cohort

DVHA is interested in testing approaches for patients with longstanding complex pain conditions. An initial review of claims data indicates that as many as 10,000 Medicaid Members have been treated for pain-related conditions for two consecutive years (2015 and 2016). In addition, DVHA would also welcome information enabling it to develop a service design intended to serve Medicaid members at risk of developing chronic pain and long-term use of opioids. Initial claims analysis shows that approximately 5,000 Medicaid Members were treated for pain-related conditions in 2016. Please provide information about approaches to cohort selection for potential pilot programs.

1. Patient Cohort

DVHA is interested to learn how a patient cohort for a pilot project could be selected. How many patients would be optimal for a 12-month pilot? We are interested in pilots serving patients dually eligible for Medicare and Medicaid. What general demographics and clinical characteristics could be included and what rationale could be offered for targeting alternative treatment services to this group. What is understood about the current total cost of care? What specific patient and system outcomes could be achieved through a pilot?

2. Selection Criteria

Is there selection criteria (instruments) that could be useful for cohort selection for pilots?

3. Patient Engagement and Consent

What strategies could be employed to recruit patients to participate in pilot services? What referral sources could be anticipated? DVHA is also interested in learning about respondent's recommendations relating to patient consent for

participating in treatment that includes consent to disclose substance use treatment information for care coordination and evaluation as well as collection of identifying information for evaluation conducted by Vermont Medicaid.

4. Cost of Care Analysis

Please provide information about what the current major cost drivers might be for a patient cohort experiencing chronic pain and what cost offsets that may potentially be realized because of the alternative treatment services that may be piloted.

II. Interdisciplinary Team(s) of Pain Specialists: Direct Services – Assessment, Care Planning, and Ongoing Evaluation

1. Team Composition

What is the ideal composition of an interdisciplinary team for this prototype framework and why? We are interested to learn more about the CAM providers that could be included on such a team and the criteria that could be used to recruit them. What could the relationship of an interdisciplinary pain specialist team be to referring primary care providers? Are there some team members that could be considered core to the interdisciplinary team members[2], and others which may be considered part of wider multidisciplinary team[3]? We are interested in receiving more information about the potential relationship between the core interdisciplinary team members and the multidisciplinary team members, including how each might contribute to a single care plan. Finally, we are interested in learning more about what discharge criteria could be developed.

2. Team Role in the Pilot System of Care

The Pilot Program Framework envisions at least three potential roles for the team(s):

- consultation & support to primary care as requested, including follow up after a time limited clinic-based service (see section III)
- assessment and development of individual plans of care for time-limited, comprehensive, and intensive clinic-based services
- provision of time-limited, comprehensive, and intensive clinic-based services

We are interested in suggestions regarding the potential roles of teams that could be tested in pilot service arrangements.

3. Team Staffing and Costs

We are considering requesting staffing plans and costs of any potential pilot proposals and seek additional information about how to collect such information in a way that supports comparability across potential pilot programs. The table below provides an initial approach and DVHA welcomes comments or suggestions for the best way to collect and analyze such information. We are also seeking information about the mix of services that are currently billable and those which may require new funding to support. What types of administrative arrangements could be employed to support the convening of this type of team?

[2] Interdisciplinary teams are diverse health professionals in teams that may also include other non-professional staff that work together in a coordinated fashion to share expertise, knowledge, and skills to impact on patient care through a combined care plan.
[3] Multidisciplinary teams are considered to be diverse health professionals contributing to patient care, but who may work on separate care plans and discipline-specific goals.

Position	% FTE	Annual Salary	Annual Benefits	Annual Total	Medicaid billable hours per week	Medicaid non-billable hours per week	Team member location

4. Referrals & Patient Assessment

If interdisciplinary teams specializing on pain were available in the Vermont system of care, what referral mechanisms and criteria could be employed to make referrals? We are interested in learning more about what could be included in an interdisciplinary assessment process. How long might such assessments take? How can pilots support sharing of patient records to facilitate integrated care? DVHA seeks recommendations for standardized assessment tools that it should consider asking potential pilot programs to use.

5. Development of an Individual Plan of Care

DVHA seeks information and recommendations for developing transdisciplinary plans of care. What potential modalities should be considered? How can care be truly individualized for each patient (modality, frequency, duration)? We are also learning that education for patients and their primary supports/family system is important -- how could this be reflected in potential pilot programs? Finally, what are recommended approaches to use by teams for setting patient-level outcomes and goals, and how can these be measured? Are there sample transdisciplinary treatment plans that could help inform the development of strong pilot proposals?

6. Payment Approach

DVHA is interested in testing a variety of payment options but is focused on making a single payment for all services related to interdisciplinary team management of chronic pain for an individual over a therapeutically appropriate period. This may include a single payment for services across multiple organizations, multiple providers, and/or multiple settings.

DVHA plans to evaluate the financial arrangements of potential pilots including transdisciplinary teams. Following is a generic approach to developing comparable cost information for two key team services: assessment and care plan. Please provide feedback on the utility of the approach described below.

Considering the team composition and the proposed roles/functions of the team, please indicate the service(s), the cost estimated of the service(s), reimbursement rate (where applicable), costs and requirements for delivery (e.g. E.H.R. modifications) and proposed overall budget for service delivery averaged per patient and for the entire cohort of Medicaid Members, itemized respectively.

	Unit Cost	Targeted number of patients in cohort	Total Cost for cohort
Interdisciplinary assessment			
Development of individual plan of care			

III. Interdisciplinary Team(s) of Pain Specialists: Consultation Services

A key goal of whatever prototype service framework DVHA adopts will be to test approaches that link specialist teams and services with primary care and complementary alternative modality (CAMs) providers.

DVHA seeks to test methodologies to support specialized pain consultation to Primary Care Providers. Various approaches include academic detailing, telehealth consults, travelling clinics, or Project ECHO[4]. We are interested in learning about which of these approaches may be most suited to the Vermont health care landscape.

DVHA requests information about what are reasonable costs for consultation services, how these can best be reimbursed and what requirements different delivery methods (e.g. telehealth, travelling clinic) entail?

IV. Comprehensive Integrated Clinic Services - Interventions

DVHA's research thus far highlights the importance of both group and individual interventions and favors the use of a range of modalities and specialties. DVHA envisions supporting specialty clinic-based interventions that provide comprehensive care on a time-limited basis to restore or improve functioning. In the proposed framework, these clinics, which could serve as the "Hub" housing the interdisciplinary team of pain specialists described earlier, would link to primary care ("spokes") to ensure coordinated care and support for the gains achieved in the time-limited, intensive services. Likely, this concentration of clinic-based services requires an organizational host to provide facilities, although more geographically dispersed arrangements could be developed. We seek information about the best approaches to pilot test comprehensive integrated clinic services.

1. Program Description

What core capabilities and attributes could comprise a comprehensive integrated clinic? What should be described in a proposed comprehensive interdisciplinary intervention program? We envision asking potential pilots to provide descriptions of the program including modalities offered, sample schedule for a patient, number of patients seen at any given time, and timeframe for patients to move through the program. DVHA seeks information and observations from respondents on how primary care practices might effectively collaborate with proposed clinics. What referral and communication processes, including outcome measurement, could be employed to support coordinated care? Finally, how should progress be measured and how can this help inform if discharge criteria from the program has been met?

[4] Project ECHO allows physicians, nurse practitioners, and other clinicians to jointly manage complex illness and promotes the use of best practices in care, while enabling patients to receive treatment in their home communities. https://www.rwjf.org/en/how-we-work/grants-explorer/featured-programs/project-echo.html

2. Staffing Plan

As with interdisciplinary specialist teams, DVHA seeks information about how to elicit staffing plans for integrative clinics that support comparability across potential pilot proposals. Please comment on the approach outlined in the following table and text. We are also seeking information about the mix of services that are currently billable and which those which may require additional funding to support. We are also interested in gaining information about the potential administrative arrangements that support the convening of the team in a clinic setting.

Position	% FTE	Annual Salary	Annual Benefits	Annual Total	Medicaid billable hours per week	Medicaid non-billable hours per week	Team member location

3. Payment Approach

DVHA is interested in testing a variety of payment options for potential pilots but favors developing a bundled payment (episode of care or other approach) for those services provided in clinics for an individual over a therapeutically appropriate period. This could include a single payment for services provided by partnering organizations and providers.

RFI respondents are encouraged to suggest payment models that they believe will align with and support their recommendations regarding program approach, given the composition of the interdisciplinary team and the range of services they recommend. DVHA seeks information that can be compared across responses and approaches and encourages respondents to present their recommendations regarding payment models both in a narrative and in a graphic or tabular format if possible. The following instructions and sample table offer one possible approach to this task, but respondents are free to present their ideas in the format they choose.

Please indicate the service(s), the cost estimated of the service(s), reimbursement rate (where applicable), costs and requirements for delivery (e.g. E.H.R. modifications) and proposed overall budget for service delivery averaged per patient and for the entire cohort of Medicaid Members, itemized respectively. Please describe in a narrative any assumptions used to establish cost estimates for each activity.

Service	Unit Cost	Targeted number of patients in cohort	Total Cost for cohort

V. Enhanced Primary Care Services

As with other chronic conditions Primary Care provides a key role in the ongoing management of chronic pain. The Blueprint for Health Patient-Centered Medical Homes and Community Health Teams are well positioned to provide coordinated multidisciplinary services. DVHA believes that primary care practices can help support the provision of CAM services by engaging local practitioners, providing "warm hand offs", and coordinating care. In addition, many primary care practices are positioned to either directly provide or coordinate mental health and substance use treatment. DVHA is seeking information about how primary care practices could engage in coordinated care with the Comprehensive Integrated Clinics (above) and how they could organize the provision of CAMS and behavioral health on behalf of their patients with chronic pain conditions.

1. Program Description

DVHA seeks information about what program enhancements to primary care services could be tested. Such enhancements may include interventions that could be offered in individual and group modalities.

The prototype program framework envisions interdisciplinary teams organizing care for a panel of patients with chronic pain. Key elements may include:

- Nursing care coordination
- Cognitive Behavioral Therapy and Trauma-Specific Treatments
- Low barrier access to CAMS
- Medical management
- Methods that will be used to uniformly collect data about each patient's treatment (including utilization of CAMs)
- Outcome measurement

DVHA seeks feedback on the above and additional recommendations.

2. Patient Activation and Education

DVHA believes that one of the most challenging and important aspects of management of chronic pain is patient activation. Patient suffering is profound and is often as impacted by loss of control, sense of hopelessness, and emotional difficulties as much as due to anatomical conditions. Instilling hope, a sense of agency for one's own health and well-being and developing alternative coping skills are described as perhaps the most important aspect of this work.

DVHA is interested in learning about approaches and methods that can be used to help empower and activate patients to develop self-care and coping skills. We are also interested in learning more about how to help activate patients' support network/family systems in coping successfully with the pain loved ones' experience.

3. Staffing Plan

As before in this document, DVHA seeks information about how to elicit staffing plans and costs for primary care enhancements that supports comparability across potential proposals. Please offer feedback on the generic approach outlined in the table below. In addition, we are seeking information about services that are currently billable and which may require additional funding to support. We are also interested in learning about the potential mix between currently billable and new funding sources to support the primary care enhancements that may be proposed by pilots. Finally, we are also interested in learning about any administrative arrangements that may be employed to support enhanced primary care services.

Position	% FTE	Annual Salary	Annual Benefits	Annual Total	Medicaid billable hours per week	Medicaid non-billable hours per week	Team member location

4. Payment Approach

DVHA is interested in testing a variety of payment options for pilots but is focused on making a single payment for the service enhancements that may be proposed. This may involve a bundled payment facilitating the services of multiple organizations, multiple providers, and/or multiple settings.

DVHA anticipates evaluating pilot proposals based on their financial arrangements. We are seeking information that can be compared across proposals. We seek information about the utility of employing a generic approach such as the following:

Considering the team composition and the proposed roles/functions of the team, please indicate the service(s), the cost estimated of the service(s), reimbursement rate (where applicable), costs and requirements for delivery (e.g. E.H.R. modifications) and proposed overall budget for service delivery averaged per patient and for the entire cohort of Medicaid Members, itemized respectively. Please describe in a narrative any assumptions used to establish cost estimates for each activity.

Service	Unit Cost	Targeted number of patients in cohort	Total Cost for cohort

9. RFI RESPONSE SUBMISSION INSTRUCTIONS AND TIMELINE

9.1 Form.

Each submission prepared in response to this RFI must include the elements listed below, in the order indicated.
The first page of the RFI response must be a cover page displaying at least the following:

- Reference to the RFI title
- Respondent's Name
- Contact Person
- Telephone Number
- Address
- Fax Number
- Email Address

All subsequent pages of the RFI response must be numbered. The response should be organized to correspond to the RFI section and subsection numbers.

9.2 DVHA/Blueprint Contact Information

All communications concerning this Request for Information (RFI) are to be addressed in writing to the attention of: Beth Tanzman, Vermont Blueprint for Health, NOB 1 South, 280 State Drive, Waterbury, VT 05671-1010. Beth Tanzman is the sole contact for this RFI Response.

9.3 RFI Response Submission

CLOSING DATE: The closing date for the receipt of RFI Responses is **3:00 p.m. on August 3, 2018.** Electronic responses should be submitted to AHS.DVHABlueprintforHealthDocumentSubmission@Vermont.gov Paper copy responses should be delivered to: Beth Tanzman, Vermont Blueprint for Health, NOB 1 South, 280 State Drive, Waterbury, VT 05671-1010 prior to that time. RFI Responses or unsolicited amendments submitted after that time will not be accepted.

Paper copies must be bound with a staple, binder or other appropriate means such that pages are not submitted loosely. The electronic response must be in Microsoft Word version 2007 compatible format.

9.4 Review and Evaluation of Responses

The review and evaluation of responses to the RFI will be performed by Blueprint staff and their designees. The evaluation process will take place the week following the response due date. During this time, Blueprint staff or their consultants or contractors may, at their option, initiate discussion with respondents for the purpose of clarifying aspects of their responses. **Responses to this RFI will be posted on the Blueprint Website:** http://blueprintforhealth.vermont.gov