STATE OF SOUTH DAKOTA
OFFICE OF PROCUREMENT MANAGEMENT
523 EAST CAPITOL AVENUE
PIERRE, SOUTH DAKOTA 57501-3182

Health Home Performance Analysis

Questions and Responses

PROPOSALS ARE DUE NO LATER THAN April 8, 2026 5:00 PM CDT

RFP # 19620 BUYER: Department of Social Services POC: Kirsten Blachford
Kirsten.Blachford@state.sd.us

Q1: Can we use our current contract with South Dakota as one of the required references? A1: Vendors with previous contractual relationships with the State may list South Dakota as a reference at their discretion.
Q2: Does DSS have an anticipated budget for this project? A2: The most recent contract was not to exceed $978,574 over a five-year period (opensd.gov)
Q3: **3.4.2-3.4.3 Heath Outcomes Analysis:** For (a) South Dakota Mediciad claims data and (b) the historical Outcomes Measure data from the prior fifteen 6-month periods, what format will DSS provide these files in, and will DSS provide accompanying documentation (e.g., file layouts/data dictionaries) for each? A3: The CSV file format.
Q4: **3.4.4-3.4.6 Health Outomes Analysis:** For each semiannual cycle, what are the expected submission widows for Health Homes, and what turnaround time does DSS expect for the vendor to validate submissions and deliver the required reports (aggregate, combined provider level, and individual health home level)? A4: Health Homes are given 30 days to submit reports with vendor deliverables expected within 30 days from the final submission.
Q5: **Program Background:** Section 1.1 references 1945A authority as the basis for the Health Homes program. Can DSS confirm this is intentional? The eligible population description, including chronic conditions, at-risk conditions, and severe mental illness criteria, appears consistent with a traditional Section 1945 Health Home structure. Understanding the correct statutory authority is important for ensuring our methodology and reporting approach aligns with applicable CMS requirements. A5: 1945 is the correct authority.
Q6: **Data Access & Transition:** What will the initial data handoff from the current vendor include? Specifically, will the selected vendor receive: (a) historical Medicaid claims data, (b) enrollment files, (c) the 15 prior collection periods of outcome measure data referenced in Section 3.4.3, (d) existing file layout documentation, and (e) prior reporting logic or analytical code? What is the expected timeline and mechanism for this transfer? *Rationale: The scope of the data handoff materially affects transition planning, ramp-up timeline, and cost.*

A6: Previous datasets and information necessary to complete the work will be made available.
Q7: Will the vendor receive the complete historical claims data set used by the current vendor, including the matched comparison group populations, or will a new baseline cohort need to be constructed? If a new baseline must be built, how many years of historical claims will be available? *Rationale: Continuity of the matched comparison methodology (Attachment C) depends on access to prior cohort data. Reconstructing a baseline from scratch has significant cost and timeline implications.* A7: Previous datasets necessary to complete the work will be made available.
Q8: What specific Medicaid claims data files will be provided to the selected vendor, in what format, and through what secure transfer mechanism? Will the vendor receive full encounter-level claims or pre-adjudicated summary data? *Rationale: File type (837, MMIS extract, etc.), data lag, and refresh frequency all materially affect methodology design and staffing.* A8: MMIS paid claims data and case management claims data will be provided in CSV format.
Q9: **Methodology & Population:** For purposes of the financial outcomes analysis, which population is being analyzed: all members eligible for Health Homes enrollment, all members actively enrolled, or only members who received at least one core service during the measurement period? Clarity on this definition is important for cohort construction and comparability across reporting periods. A9: Only those members that received a core service during the measurement period will be included in the analyzed population for financial outcomes analysis.
Q10: Attachment C describes a pre/post matched comparison methodology. Is DSS open to the selected vendor proposing a materially different methodology (e.g., difference-in-differences, propensity score matching variants, synthetic controls), or is the expectation that the core pre/post matched design is retained with incremental refinements only? *Rationale: Section 3.2 asks offerors to propose modifications, but the evaluation criteria weight familiarity with existing methods — clarifying the appetite for methodological change is important for proposal framing.* A10: DSS is open to new a comparison methodology provided there is sound and logical evidence to justify the departure from past methodologies.
Q11: **Scope & Change Management** Section 3.4 notes that outcome measures and file layouts are subject to change. If CMS or DSS modifies the measure set, file structures, or reporting requirements during the contract term, is the vendor expected to implement those changes within the base contract scope, or would such changes be handled through a contract amendment or change order process? *Rationale: The cost and effort of mid-contract changes can be significant depending on the frequency and scale of updates.* A11: Significant mandated changes would be eligible for contract amendment consideration.
Q12: Will the vendor be expected to develop and maintain the provider-facing portal or submission template for outcome measure collection, or does DSS maintain that infrastructure separately? If the vendor is responsible, are there existing technical specifications or is this a greenfield build? *Rationale: Section 3.4.4 references "facilitating outcome measure submissions" but does not clarify whether the vendor owns the submission infrastructure or simply processes files delivered through a state-managed system.*

A12: Yes, the vendor is responsible for the development and maintenance of a template/portal for data collection. Technical requirements need to ensure the secure transfer of data both to and from the providers and DSS staff.

Q13: Regarding Section 3.5 (other related tasks at the State's request): should offerors assume an hourly rate structure for this work in their cost proposals? What would the approval process look like for task assignments under this provision, and is there an anticipated annual volume of hours or a not-to-exceed threshold?
Rationale: Without pricing and approval structure guidance, it is difficult to scope this element responsibly.

A13: Offerors should include an hourly rate for items in this category in their proposal. Tasks/projects in this category will have scope, duration, and NTE thresholds discussed and agreed on between the Vendor and the State prior to task/project commencement.

Q14: Approximately how many Health Home providers are currently active in the Care Connect program, and how many are CMHC-based versus primary care-based? What is the approximate total enrolled member population?
Rationale: Provider count and member volume directly drive the effort estimate for outcome measure collection, validation, and semiannual reporting obligations under sections 3.4.4–3.4.6.

A14: This information can be found on the DSS.gov website; enrollment- https://dss.sd.gov/keyresources/statistics.aspx ; provider list- https://powerbiapi.appssd.sd.gov/embedpowerbiweb/DSS/Medicaid/GetProviderListReport

Q15: **Deliverables:** Are there prescribed formats, templates, or branding requirements for the semiannual quality reports and annual financial outcomes report, or does the vendor have discretion over report design and structure? Will DSS provide examples of prior deliverables as reference?
Rationale: Understanding whether the State expects a standardized format or will accept the vendor's own reporting framework affects both proposal design and the level of effort required for report development.

A15: DSS will provide prior examples, but the Vendor will have discretion over format and design.

Q16: **Contract & Logistics:** Does the State have an established budget or not-to-exceed contract amount for this engagement? If so, can that figure be shared to help offeror's structure appropriately scoped cost proposals?
Rationale: The total contract amount in Section 2.5 is left blank. Without at least a general budget parameter, it is difficult to calibrate level of effort and deliverable detail to the State's expectations.

A16: Offerors should present their most competitive bid. The most recent contract was not to exceed $978,574 over a five-year period (opensd.gov)

Q17: Given the anticipated award date of April 29 and contract start of June 1, 2026, and the financial outcomes analysis deadline of August 31, 2026, will the vendor have access to a full year of clean claims data by contract start, or will the first deliverable necessarily be based on a partial-year dataset?
Rationale: A roughly 90-day ramp to the first major deliverable is tight. Understanding data availability at contract start is essential for structuring a realistic delivery timeline.

A17: A full year of claims data will be available upon contract start.

Q18: Is on-site presence in Pierre expected, preferred, or optional for this engagement? If on-site work is anticipated, can DSS provide an estimate of the frequency or number of visits expected annually?

A18: On-site presence is optional.
Q19: Does the State anticipate requiring an oral presentation for this procurement, and if so, will presentations be conducted in-person in Pierre or via video conference? *Rationale: Section 1.15 notes that oral presentations are at the State's discretion. Given the geographic location, this affects travel cost planning.* A19: If oral presentations are required, they will be held via video conference.