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STRATEGIC RFP SCORECARD

Five-Year TCO of Healthcare IT Operations

In-House, Co-Managed and Fully Managed Models

A procurement framework for U.S. healthcare CIOs, CFOs, IT directors and sourcing teams. Prepared 13 October 2026. Compare the complete operating cost, the clinical service commitment and the responsibilities your organization retains. Use the accompanying Excel workbook to calculate costs and record proposal scores.

The decision this scorecard supports

Which operating model can meet our clinical, security and service requirements at an acceptable five-year cost, with clear accountability and a workable exit?

Model	Operating Responsibility	Costs Often Overlooked
In-House	Internal team operates the agreed scope. Specialist vendor support may still be needed.	After-hours coverage, vacancies, tools, recovery testing and management time.
Co-Managed	Internal team and provider divide services through a written responsibility matrix.	Duplicated tools, handoff overhead, uncovered tasks and retained staffing.
Fully Managed	Provider operates the contracted scope. Internal owners retain governance, budget and clinical decisions.	Retained governance, excluded EHR support, onsite charges, transition and exit.

How to use the toolkit

Agree one service baseline. Complete mandatory gates. Build comparable cost estimates. Score documented evidence. Test the assumptions. Record the selection and contract conditions.

Evidence boundary: This is an editorial procurement framework informed by official and primary sources. The weights and numerical example are illustrative. They are not an official industry standard, verified market benchmark or vendor quote. No model is inherently the lowest-cost choice.

02 / Normalize the service scope

Require every proposal and internal operating plan to price the same population, assets, service hours and clinical requirements. A lower fee with missing services is not a comparable offer.

Baseline field	Specify before issuing the RFP
Organization and scale	Sites, users, endpoints, providers, servers, cloud workloads, storage and expected growth.
Clinical applications	EHR/PM, patient portal, eRx, labs, imaging, telehealth and the associated vendor support boundaries.
Integration operations	HL7/FHIR interfaces, APIs, integration engines, message volumes, queue monitoring, retry and reconciliation.
Coverage	Clinical operating hours, after-hours response, onsite needs, remote support and incident severity definitions.
Resilience	Service-specific recovery time objective (RTO), recovery point objective (RPO), restore testing and downtime workflows.
Security and compliance	Applicable HIPAA duties, access controls, patching, risk assessments, incident handling and evidence retention.
Commercial boundary	Tools, hosting, specialist services, taxes, refresh, project work and third-party costs included or excluded.

Assign one accountable owner to each activity

Activity	Internal owner	Provider owner	Included in fee?
Service desk and escalation	_____	_____	_____
EHR and interface support	_____	_____	_____
Security and incident response	_____	_____	_____
Backup and clinical recovery	_____	_____	_____
Change approval and reporting	_____	_____	_____

Use an accountable/performing/consulted/informed responsibility matrix in the contract. Record subcontractors and third-party vendor dependencies. Staffing and service capability must support the baseline; a financial FTE assumption alone does not prove coverage.

Source basis: HealthIT.gov SAFER Guides; HHS cloud guidance; NIST SP 1305.

03 / Build the five-year cost boundary

Five-year cash TCO=Year 0 transition + Years 1-5 operating costs + refresh + exit - residual asset recovery.

Cost group	Required inputs and controls
Internal labor	Paid FTE, role mix, salary, incremental employer load, salary inflation and explicit FTE growth. Retain governance labor in all models.
Coverage and workforce	Incremental on-call pay, temporary coverage, recruitment, turnover and annual training. Avoid adding pay already included in salary or employer load.
Provider services	Recurring fees, annual escalation, billable units, pass-through charges, minimum commitments and overage rates.
Technology and applications	Hosting, network, licensing, security tools, EHR vendor support and integration specialists outside the provider fee.
Continuity and compliance	Backup, recovery tests, clinical downtime exercises, assessments, audits and documentation.
One-time and exit	Remediation, migration, initial training, dual running, refresh purchases, handover and export costs. Deduct realizable residual value.

Calculation conventions in the workbook

- Internal labor = paid FTE x salary x (1 + employer load). Salary inflation and FTE growth compound separately.
- Recurring costs = Year 1 amount x (1 + applicable escalation) raised to year minus one.
- Transition occurs at Year 0. Refresh occurs in the chosen year. Exit and residual recovery occur in Year 5.
- Present value = Year 0 cost + each annual cash cost divided by (1 + nominal discount rate) raised to that year.

Cash costs exclude depreciation and financing. Model any applicable taxes, facilities or insurance in Other recurring operations. Do not add depreciation to a model that already includes the asset purchase. Include the same underlying application costs across models or clearly identify them as common excluded costs.

Keep disruption losses separate

An optional outage-risk analysis should disclose event probability, affected workflow, recoverable versus lost revenue, incremental response cost, and uncertainty. Do not add an industry-average breach cost to every annual TCO estimate. This workbook does not calculate disruption losses.

Source basis: GAO Cost Estimating Guide; BLS compensation resources; Health IT Playbook pricing template.

04 / Example Five-year calculation

Example only. The following figures demonstrate the workbook.They are invented planning assumptions, not quotations, market rates, savings claims or a recommendation.

Key assumption	In-house	Co-managed	Fully managed
Internal paid FTE	6.0	3.0	1.5
Annual salary per paid FTE	$110,000	$110,000	$130,000
Employer load / salary	30%	30%	30%
Year 1 provider service fee	$0	$300,000	$700,000
Year 0 transition	$40,000	$90,000	$140,000

All recurring cost categories escalate by 3% annually in the starting example. Paid FTE growth is 0%. All models include a $180,000 refresh in Year 3. Exit allowances are $20,000, $45,000 and $75,000 respectively. Residual recovery is $0. Nominal discount rate is 5%.

Cash cost period	In-house	Co-managed	Fully managed
Year 0	$40,000	$90,000	$140,000
Year 1	$1,353,000	$1,129,000	$1,271,500
Year 2	$1,393,590	$1,162,870	$1,309,645
Year 3	$1,615,398	$1,377,756	$1,528,934
Year 4	$1,478,460	$1,233,689	$1,389,402
Year 5	$1,542,813	$1,315,699	$1,506,084
Five-year TCO incl. Year 0	$7,423,261	$6,309,014	$7,145,566
Present value incl. Year 0	$6,413,207	$5,455,997	$6,182,711

Interpret the result correctly

The lowest illustrative total reflects the selected inputs. It does not establish that the corresponding model is cheaper for a real health system. An actual comparison must confirm equivalent scope, staffing capacity, fee inclusions, clinical recovery and evidence quality.

Replace every yellow cost input before procurement. Mark each model Validated only after financial and service owners review the numbers. Record the source, quote date and inclusion boundary in the workbook evidence notes.

05 / Apply mandatory qualification gates

Complete these checks before using weighted scores to compare options. A failed gate blocks qualification. A pending gate requires further evidence. These are proposed procurement gates; apply relevant legal and organizational requirements.

Gate	Evidence required
Applicable HIPAA and BAA arrangements	Clear ePHI roles, applicable business associate terms, subcontractor duties and incident reporting responsibilities.
Clinical continuity and recovery	Service-specific RTO/RPO, recent restore test results, dependencies, downtime workflows and recovery acceptance.
Coverage and accountable staffing	Coverage schedule, named roles, escalation path, onsite arrangements and retained internal owners.
Complete scope and comparable pricing	Five-year pricing, inclusion/exclusion schedule, escalation terms, pass-through costs and priced out-of-scope work.
Exit and access control rights	Handover terms, export access, credential ownership, documentation availability and subcontractor arrangements.

Record Pass, Fail or Pending

Gate	In-house	Co-managed	Fully managed
HIPAA / BAA arrangements	_____	_____	_____
Clinical continuity / recovery	_____	_____	_____
Coverage / accountability	_____	_____	_____
Scope / pricing completeness	_____	_____	_____
Exit / access rights	_____	_____	_____

Reviewer: _____ Review date: _____

For the in-house model, assess the internal plan and any suppliers used within it. Fully managed operations still require internal accountable owners. Where a legal arrangement is not applicable, document why and evaluate the remaining obligations.

Source basis: HHS Security Rule and cloud guidance; SAFER Guides; NIST supplier risk guidance; HSCC OCCI. HHS cybersecurity performance goals are voluntary priorities, not independent legal mandates.

06 / Score qualified options consistently

Approve weights before reviewing proposals. Score evidence against the same requirements. Use the Excel RFP Scorecard tab to calculate the total; blank ratings remain Pending.

Evaluation criterion	Weight	In-house	Co-managed	Fully managed
Five-year cost and price transparency	25%	_____	_____	_____
Clinical continuity and recovery	20%	_____	_____	_____
Security and applicable compliance	15%	_____	_____	_____
EHR and integration operations	10%	_____	_____	_____
Staffing, coverage and escalation	10%	_____	_____	_____
Governance and retained control	10%	_____	_____	_____
Transition and service acceptance	5%	_____	_____	_____
Exit rights and portability	5%	_____	_____	_____
Total	100%	_____	_____	_____

Score each criterion from 0 to 5

Score	Evidence anchor
0	Does not meet the requirement.
1	Claim only. No usable supporting evidence.
2	Partial evidence or material gaps.
3	Meets the requirement with documented evidence.
4	Demonstrated capability that exceeds the requirement.
5	Independently verified or reference-validated excellence.

Weighted score / 100 = sum of (criterion weight x rating / 5). Weights are entered as percentage points in Excel, such as 25. Eight ratings of 3 produce a score of 60. The weight total must equal 100. The cost criterion should consider verified TCO, price certainty, and exclusions together. Lowest price alone does not prove a score of 5. Evidence supporting operational strengths should be relevant to comparable clinical scope.

Source basis: Acquisition.gov evaluation-factor guidance is a design reference. These specific weights and rating anchors are editorial recommendations, not FAR requirements for private healthcare procurement.

07 / Request evidence that supports each score

Criterion	Questions to ask and evidence to request
Cost and price transparency	Provide Year 0 and Years 1-5 prices. Identify fee units, escalation caps, minimums, overages, taxes, third-party charges and all exclusions. Reconcile the quote with the workbook.
Clinical continuity	Show the most recent recovery exercise for comparable services. What was actually restored? Identify test date, achieved recovery times, data loss, clinical validation and unresolved actions.
Security and compliance	Who owns access reviews, patching, risk assessments and incident handling? Supply relevant assessment findings, remediation evidence and contract responsibilities.
EHR and integration operations	Who monitors interfaces and resolves message failures? Supply runbooks, queue alerts, reconciliation procedures, vendor boundaries and change testing evidence.
Staffing and coverage	How is after-hours demand covered? Supply role mix, coverage schedule, escalation rota, onsite response arrangements, surge capacity and vacancy contingency.
Governance and control	Which decisions remain internal? Supply a responsibility matrix, service review sample, reporting cadence, change approvals and access to asset/configuration records.
Transition and acceptance	Provide discovery, remediation, knowledge transfer, parallel running and acceptance milestones. Who funds defects discovered during transition?
Exit and portability	Show handover obligations, export formats, documentation, credential transfer, license portability, subcontractor dependencies and termination charges.

Record evidence so another reviewer can verify it

For each rating, capture the document or demonstration, date, scope, reviewer, key limitation and any required follow-up. A certification or attestation can inform review, but it does not by itself prove clinical recovery or full service coverage.

For internal operations, request the same operating evidence: staffing coverage, incident history, asset records, restore tests and approved budgets. Do not waive evaluation because the work is already performed in-house.

Source basis: NIST SP 1305; HSCC HIC-SCRiM; CISA MSP advisory; SAFER Guides.

08 / Turn service promises into contract terms

Contract decision	Specify and verify
Service severity	Define priorities by clinical consequences and affected workflows. State who can declare a critical incident and bypass routine support tiers.
Response versus restoration	Separate acknowledgement, expert engagement, workaround and restoration targets. State the clock start, coverage window, exclusions and escalation rules.
Clinical recovery acceptance	Require EHR access, interfaces, medication/order workflows and data reconciliation to pass agreed checks before declaring recovery complete.
Security incident coordination	Define notice, contacts, joint investigation, evidence access and subcontractor reporting. Align applicable legal duties with contractual commitments.
Commercial protections	Define fee units, annual increase terms, pass-through markups, change-order approval and rate cards. Credit remedies do not substitute for recovery capability.
Change and project boundaries	Distinguish routine maintenance from chargeable change, new interfaces, site expansion, migrations and major upgrades. Require price approval before work.
Governance and records	Require usable asset inventories, configuration records, runbooks, performance reporting, access reviews and an agreed escalation owner.
Exit and handover	Specify notice, assistance hours, export delivery, credential transfer, license handling, document completeness and secure access revocation.

Test the contract against a clinical outage scenario

An interface outage delays critical results after hours. Identify the detecting team, incident owner, EHR/lab vendor contacts, workaround, escalation clock, validation steps and who pays for specialist work. Resolve any gap before signature.

Legal and procurement teams should align actual contract clauses with applicable obligations and organizational risk tolerance. Refresh current legal requirements before issuing the RFP.

Source basis: HHS guidance; NIST contingency and supplier guidance; CISA MSP advisory; HSCC continuity resources.

09 / Record the decision and unresolved conditions

Decision field	Complete during review
Organization / evaluation owner	_____
Scope version / quote dates	_____
Selected model / provider	_____
Five-year cash TCO / present value	_____
Mandatory gates / weighted score	_____
Largest cost uncertainty	_____
Retained staffing and responsibilities	_____
Conditions before service acceptance	_____
Required contractual changes	_____
Finance / IT / clinical / legal sign-off	_____

Use the Excel workbook in this order

- Inputs: replace illustrative values, confirm scope inclusions, and record evidence. Set a first operating year, discount rate, and refresh year.
- Cost Build: review labor calculations, recurring categories, one-time cash costs, and annual totals for each model.
- RFP Scorecard: complete mandatory gates, approve weights, score evidence and record reviewer notes.
- Summary: compare cash TCO, present value, annual costs, evidence status, qualification and scores.
- Guide: review definitions, calculation conventions, and linked primary sources.

Test whether the decision survives uncertainty

Change the largest assumptions individually: vendor escalation, internal FTE growth, provider fees, excluded specialist work, refresh timing and exit cost. Review annual budget peaks as well as total TCO. The workbook recalculates the current inputs; it does not retain scenario snapshots.

Approve a model only after scope gaps, evidence gaps and contract conditions are resolved. Document why the selected combination of cost, capability and retained control fits the organization.

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10 / Official and primary source register

These sources inform methodology and evaluation requirements. None supplies a universal five-year dollar comparison of all three operating models. Numerical assumptions and scoring weights in this toolkit are editorial.

GAO Cost Estimating Guide (2020)
Cost methodology and uncertainty.

BLS OEWS wage tables
Use local role data for salary inputs.

BLS Employer Costs for Employee Compensation
Employer cost components; no blanket healthcare load.

BLS Employment Cost Index
Historical labor escalation; not a forecast.

Health IT Playbook: EHRs
EHR vendor pricing and cost categories.

HHS HIPAA Security Rule summary
Applicable safeguards and BAA responsibilities.

HHS HIPAA cloud guidance
Cloud/customer responsibility allocation.

HHS Healthcare Cybersecurity Performance Goals
Voluntary security priorities.

HealthIT.gov 2025 SAFER Guides
EHR safety, contingency and system management.

NIST SP 800-34 Rev. 1
Contingency planning method.

NIST SP 1305 (2024)
Supplier security requirements.

HSCC HIC-SCRiM 2023
Healthcare supplier risk toolkit.

HSCC OCCI checklist
Extended outage and clinical continuity.

CISA MSP cybersecurity advisory (2022)
MSP/customer security practices.

FAR 15.304
Evaluation design reference; not a private hospital mandate.

How to interpret the evidence

GAO provides general cost-estimating practice. BLS supplies labor reference data, not healthcare MSP quotations. HealthIT.gov EHR resources inform clinical application costs and safety. NIST and HSCC provide operational and supplier risk frameworks. HHS legal guidance and voluntary performance goals serve different purposes. FAR is a federal procurement reference, not an automatic private-provider obligation.

Review source editions, legal status and contractual requirements when updating the RFP. Use actual payroll, inventories and comparable provider quotes to replace the example.