RFA # 0707301113
Questions and Answers

Clarification:

- **Attachment 12 (Budget Template) was updated to correct the asterisks incorrectly referenced at the bottom of the page. The updated version is posted on the Department website with the RFA at: www.nyhealth.gov/funding.**

Reminder:

- **Applicants proposing to serve Bronx, New York, Queens, Suffolk or Kings Counties are reminded that they CANNOT propose to serve the entire county. These applications should identify a specific proposed service area by neighborhood or street within the proposed county.**
- **Page 2 of the RFA gives an incorrect e-mail address for requests for electronic copies of the Operations Manual. The correct address is bcdscal@health.state.ny.us**

General Questions

1. **When is the letter of intent due?**

   Letters of intent are due by November 14, 2007.

2. **Can you make the Cover Page (Attachment 8) available in an editable file instead of a PDF?**

   Yes. The Cover Page (Attachment 8) will be available as a Word, editable, document. This document will be posted on the NYS Department of Health website along with the RFA and other related documents at: www.nyhealth.gov/funding.

3. **Has any other Agency in Oneida, Herkimer, and Madison County area responded to this RFA? The question is asked so that we are made aware of the agency to contact them for collaboration on the RFA.**

   While letters of intent are encouraged, they are not required. The CSP will not know who is applying until applications are received on December 7, 2007.

Intent, Background and Program Description

4. **Section I. Introduction, first paragraph, page 1: The community-based programs to be elicited by this RFA are referred to in this paragraph as Cancer Services Program partnerships. My question is, if we were to be**

awarded a grant for one of these programs, would we have to change our name? We chose the name, Queens Healthy Living Partnership, in part to reassure our Asian clients. In the Chinese culture, and also to some extent in the Korean culture, the word "cancer" is associated with death. We have found it best to avoid the use of the word "cancer" in our promotions, substituting "healthy living" instead. Changing our name to "Cancer Service Program Partnership" would almost certainly deter some Asian clients from seeking help through our Partnership.

5. **Is there going to be a program name change for any or all partnerships that receive funds from cancer screening program, i.e. from "Healthy Living Partnership" to "Cancer Services Partnership"?**
6. **The recent RFA for breast, cervical and colorectal screening services sounds very much like a program called Women's Healthy Partnership (for breast and cervical). Is this the same program or a similar program? Are they in any way linked?**

   Earlier this year, the NYSDOH Cancer Services Program (CSP) adopted the new name, CSP Partnerships, to refer to the contractors providing breast, cervical and colorectal cancer screening, diagnostic services and follow up care. These were formerly referred to by the CSP as Healthy Living or Healthy Women's Partnerships. This new name better reflects the integration of the three screening services and acknowledges that the programs serve both men and women. The CSP uses this name on internal and external reports and documents and will use it to promote the programs on a statewide level. To the extent possible, the CSP would like partnerships to use the name "CSP Partnership" to build name awareness and consistency for clients across the state. Individual contractors may, however, develop names appropriate to the local partnership, as long as they reflect the scope of services available to the entire community served and receive CSP approval.

7. **Will we be able to keep individual county identities, or does the partnership require a merged identity?**

   The partnership name should be reflective of the entire proposed service area. For example if a partnership serves both Jones County and Smith County, the partnership name might be, "Cancer Services Program Partnership of Jones and Smith Counties". To the extent possible, the CSP would like partnerships to use the name "CSP Partnership" to build name awareness and consistency for clients across the state. Individual contractors may, however, develop names appropriate to the local partnership, as long as they reflect the scope of services available to the entire community served and receive CSP approval.

8. **On P. 1, Section A. I. Purpose, please clarify what is meant by the term "single entry point." Currently a client may enter the program either by going directly to a program provider (in response to an in reach effort, for example), or through the Partnership office.**

Single entry point in this instance does not refer to a single, physical site. It refers instead to the integration of partnership coordination of breast, cervical and colorectal cancer screening and other services provided so that men and women are offered all of the screenings for which they are eligible.

9. **On page 1 paragraph 2 (The coordination of the programs on the local level will provide a single point for the priority populations to access the vital cancer screening services)-Does this mean only one telephone number (1 toll free telephone number with 1 local telephone number) and/or one location for intake be allowed for each partnership?**

   Single entry point in this instance does not refer to a single, physical site. It refers instead to the integration of partnership coordination of breast, cervical and colorectal cancer screening and other services provided so that men and women are offered all of the screenings for which they are eligible. Enrollment does not have to take place in one location, nor does there have to be one telephone number. Depending upon the successful applicant's intake system, enrollment can take place at the lead agency, a partnering agency (community-based partner or clinical service provider) or both.

10. **Again, with regards to P. 1, Section A. 1., current partnerships include providers (such as radiology facilities) that do not offer all 3 screening modalities. Will such providers still be permitted to be part of the new integrated Partnerships?**

    Yes. Partnerships are required to establish and maintain a comprehensive provider network for breast, cervical and colorectal cancer screening and diagnostic services and treatment referrals and, for prostate cancer, diagnostic services and treatment referrals. The provider network should maximize access to, and quality of, care and ensure a sufficient number of appropriate types of providers participating in the partnership.

11. **Do we need providers and partners to approve the RFA? Can this be done via e-mail, teleconference, or in person meeting?**

    This is not a requirement. However, applications should include letters demonstrating collaboration with other community partners (RFA, p. 34) and the Partnership Assessment Tool (RFA, p.32).

12. **We are part of the Healthy Living Partnership in Westchester County. What is the difference if we apply for this RFP?**

    Any organization meeting the eligibility requirements stated in the RFA (Section II, p.12) may apply to be the lead agency. Roles and responsibilities of the lead (contracting agency) and partners (including clinical providers) are described in Section III. Project Narrative/Work plan Outcomes, pp. 15-20. Contracts with

existing CSP Partnerships will end on March 31, 2007 and will be replaced by the awardees of this RFA.

13. Mobile mammography unit – currently 9 hospital based programs

- **Could Cayuga Medical Center, as a provider, bid on this portion of the contract for a mobile mammography unit?**
- **Can this be justified since Tompkins and Cortland are combining?**
- **Would this be part of this RFA or is it a separate application?**

This RFA (#707301113) is not intended to fund mobile mammography providers. However, mobile mammography providers can be partners.

14. Section C, 1, page 6, reference is made to "hospital-based mobile mammography vans." Must a mobile mammography van be hospital-based or hold hospital contracts in order to be an eligible provider in the CSP Partnerships?

This section refers to the mobile mammography initiatives funded by the NYSDOH CSP which are all hospital-based. Applicants may partner with any properly credentialed mobile mammography unit to provide the required services as described in this RFA.

15. Page 10 of the RFA indicates that mammography or breast ultrasound will be reimbursed for females age 18-39 that are at high risk for breast cancer. Is the breast ultrasound something new for screening?

The CSP does not reimburse or support screening breast ultrasound. In women ages 18-39, diagnostic ultrasound is the most appropriate modality for a palpable breast finding. Please see the CSP Operations Manual for additional information.

Who May Apply

16. On page 5 of the RFA in the Program Description section, paragraph 2, line 7, should respondents to this RFA be only existing NYS-funded CSP partnerships?

No.

Screening Goals

17. For total screening goal, what is the reference range for age? (Page 58)

The screening goal ranges provided on page 58 represent women ages 40 and older and men ages 50 and older. See page 12, section A.1.B.

18. **Attachment 4, p. 59. What was the public source data used to calculate the "estimate of eligible priority population in each county"?**
19. **Screening Goal Ranges by County - page 58: Please clarify how these screening goal ranges were determined. I use the figures provided by the U.S. Census for Queens County for my target range of age-appropriate clients, and then multiply by 30%, which is the approximate rate of the uninsured in Queens. By that calculation, my estimate of the target population, *for women alone,* is more than twice the 40-50,000 indicated by the Screening Goal Range for both men and women. Even if some allowance is made for income level, the Screening Goal Range for Queens County appears to be dramatically understated.**

    The screening goal ranges are based on an estimate of the eligible priority population using data from the U.S. Census and New York's Behavioral Risk Factor Surveillance Survey (BRFSS). The eligible priority population includes women age 40 and older and men age 50 and older who are uninsured or underinsured and are at or below 250% of the federal poverty level in each county. The screening goal ranges provided on page 59 of the RFA reflect 20% of the estimated eligible priority population. The program is currently serving between 11% and 15% of the estimated eligible population in New York State.

20. **The screening goal suggested in the RFP is based on an estimate of the eligible priority populations in each county that includes women age 40 and over and men age 50 and over who are un or underinsured and at or below 250% of the federal poverty level. If we are providing cervical screening to women age 19-39, should we increase our screening goal by calculating that population?**
21. **Screening Goal Ranges (pp. 58-59) on p.12 Section b 1st paragraph, these ranges are identified as representing women age 40+ and men age 50+, etc. With an additional statement that *An applicant's screening goal may include estimates of eligible women who are not in the priority population (18 to 39 years of age).* If, for instance, we select a CSP identified goal of 1,000, will 18-39 year olds be included in that number or in addition to?**

    Screening goals may be increased to accommodate women ages 18 to 39. Note that performance measures as listed in Attachment 3, page 57 should also be taken into consideration when setting screening goals. Performance measures relate to the eligible priority populations. For example, performance measure #1 is a measure of the percent of screening mammograms provided to women ages 50 and older. In selecting screening goals, the applicant is ensuring that it can meet not only the screening goal but also the performance measures (Attachment 3) which relate to eligible priority populations, quality of screening services provided and other key program management activities.

22. **In the past years Cortland County screening goal for breast and cervical has been 275 women a year. Why is the screening goal for the new RFA changed**

to 151-200 people? This is very low screening goal and not an accurate view of the amount of people we screen each year in Cortland County.

23. **Target numbers this year for Genesee County for breast, cervical and colorectal screening are higher than the estimated target number of 300 for the next grant cycle. Is this because individuals receiving more than one service, e.g. breast and cervical screening count as one?**

    The screening history of 275 presented above for Cortland County represents the number of screenings performed. The new screening goals described in this RFA represent the number of people screened. Screening goals in this RFA differ from the current contractor screening goals in that they represent the total number of individuals provided with any type of breast, cervical and/or colorectal cancer screening through the program. As per the RFA, p. 32, applicants may propose a screening goal that is higher than the proposed county goal ranges in Attachment 4, demonstrate the ability to meet this goal and describe why it was selected. **Note:** In selecting screening goals, the applicant is ensuring that it can meet not only the screening goal but also the performance measures (Attachment 3) which relate to eligible priority populations, quality of screening services provided and other key program management activities.

24. **Our partnership is currently integrated and receives goal numbers for Breast & Cervical screenings and Colorectal screenings separately. The RFA specifies ranges of "number of people to be screened" for each county on pages 58 and 59. Does this number include both Breast & Cervical and Colorectal screening goals?**

    Yes. Note that current partnership screening numbers are based on the number of screenings provided. Screening goals in this RFA differ from the current contractor screening goals in that they represent the total number of individuals provided with any type of breast, cervical and/or colorectal cancer screening through the program.

25. **Are the Breast, Cervical and Colorectal screening goals now considered one in the same, or interchangeable, with one common, total goal?**

    The screening goal reflects the number of people screened, not the type of screening.

26. **Page 12 of the RFA indicates that the screening goal represents the total number of individuals provided with any type of breast, cervical and/or colorectal cancer screening through the program. In the past, it was just breast and colorectal cancer, is this new? So if a woman only receives a pap smear, will it count as 1 screening?**
27. **For the screening numbers, if a cervical screening only is done on a patient, does that person count as a "person served?"**

Yes, this is new to this RFA. The screening goal reflects the number of people screened, not the type of screening. Applicants should develop plans to meet not only the proposed screening goal but also the performance measures which relate to eligible priority populations, quality of screening services provided and other key program management activities.

28. If a program eligible, 50 year old woman receives a Pap test, CBE, Mammogram and Colorectal screening through the program, is this considered 1 screening toward the goal number or is the partnership still credited 1 Breast & Cervical screening and 1 Colorectal screening?

This is one person screened. The screening goal reflects the number of people screened, not the type of screening.

29. RE: Pg. 58 – Is the number represented here unduplicated head counts? Meaning, if a woman has breast, pap and colorectal screenings (or a man has a colorectal screening) would that count as only 1 in this screening number? Also, do you want us to figure in short term recall into the screening numbers?

The number of people to be screened on page 58 refers to unduplicated individuals screened through the program. The screening goal reflects the number of people screened, not the type of screening.

30. If Breast, Cervical and Colorectal screenings are all included in 1 total screening goal #, how do we determine goal #s for each? For example, if the total screening goal is 2000, and we are not to break out Breast & Cervical screening #s from Colorectal screening #s, then hypothetically we could screen only 5 Colorectal clients, with 4 of them being male, and our total goal performance measure would be met primarily with Breast & Cervical clients and our # of Males screened % would be high.

Applicants do not need to determine screening goals for each type of screening service. The screening goal reflects the number of people screened, not the type of screening. The example presented is inaccurate because performance measure #4 which measures the percent of male clients screened is calculated using the total number of persons screened, not the number of colorectal screenings offered (Attachment 4, p. 57).

31. How will goal achievement be counted (see below)?
a. If a woman age 20 only receives a pelvic exam and a PAP test (because that's all she is eligible for) will she be counted as "1" towards our screening goal?
Yes.
b. If a woman age 52 has a mammogram, a PAP test and an FOBT, is she counted as "1" or as "3" for our screening goal?

One.

c. If that same woman has only a CBE & a mammogram is she counted as "1" towards the screening goal or does she have to have the full range of screenings that she is eligible for to be counted in our screening goal?

One towards the screening goal. Please note that performance measure #7 measures the percent of comprehensive, age appropriate screenings offered.

d. If a woman over age 50 has only an FOBT is she counted as "1" toward our screening goal?

One towards the screening goal. Please note that performance measure #7 measures the percent of comprehensive, age appropriate screenings offered.

32. Section III.A.3, refers to required screening & diagnostic activities - Is a client vaccinated for HPV but receiving no other services, counted as a person screened? Similarly, is a client diagnosed with prostate cancer and receiving case management services, counted as a person screened?

No, neither of these clients would be counted as an individual screened.

33. In partnerships where 2 or more counties are applying together, will each county need to meet their own screening numbers?

The partnership is responsible for ensuring that the screening goals are met throughout the entire service area. At this time, the CSP intends to provide reports for each partnership as a whole. The performance measure #8 is the exception, it will be reported to the partnership by county as it is a measure of the annual screening goal completed in each county in the proposed service area.

34. Will the number of people to be screened on page 58 of the RFA be increased if the program has consistently demonstrated that the estimated priority population screening goals have exceeded the goals stated in the RFA?

Screening goals in subsequent grant years (years 2, 3, 4, and 5) may be adjusted to reflect performance from the previous year.

<u>Service Areas</u>

35. RFA Pg. 14: "Lead agencies may submit only one application per partnership. An applicant may be the lead on more than one partnership as long as separate applications are submitted for each proposed partnership." The Southern Tier Healthy Living Partnership is proposing to be lead agency, covering 6 counties that would include 2 of the county groupings/boxes in Table 1 on page 13 of the RFA. Does this mean that we need only to submit 1 application or would the 2 county groupings/boxes in Table 1 be considered 2 separate partnerships for the NYSDOH purposes and therefore require us to submit 2 separate applications?

This is considered one partnership. One application should be submitted reflecting the entire service area covered by the partnership. At a minimum, counties must combine according to the pairings listed in Table 1, p.13 in the RFA. Partnerships can be comprised of any number of service areas, as long as those combinations include those listed in Table 1, and the partnership screening goal does not exceed 5,000.

36. What criteria were used to determine the pairing of counties for this RFA?

37. Why are we combining counties? Is this to make less work for the State because this will certainly make more work for the counties that are being combined?

County estimates of eligible populations and costs to implement all required activities were compared and decisions were made to best maximize fiscal resources and implement efficiencies of scale. Counties in which 20% of the estimated eligible population is less than 300 persons were determined not to be as cost efficient as stand-alone partnerships. Therefore, these counties were partnered with other counties.

38. Our county Healthy Living Partnership would prefer to be a solo county partnership and we meet the requirements for being a stand alone county (screening more than 350 people in an integrated program), can we apply without the other county?

Counties in which 20% of the estimated eligible population is less than 300 persons are not able to apply to be individual partnerships. Current partnership screening numbers represent the number of screenings provided, not the percent of eligible persons to be screened. Screening goals in this RFA differ from the current contractor screening goals in that the screening goals in this RFA represent the total number of individuals provided with any type of breast, cervical and/or colorectal cancer screening through the program. At a minimum, counties must combine according to the pairings listed in Table 1, p.13 in the RFA.

39. Is Wyoming County permitted to make application under this RFA either individually or in partnership with other members of the Western New York Public Health Alliance?

40. It doesn't make sense (for Livingston County) to be paired with Wyoming County. I therefore am requesting reconsideration of this grouping and requesting that Livingston and Monroe Counties be permitted to carry on with the system and protocols already established.

In Wyoming and Livingston Counties, 20% of the estimated eligible population is less than 300 persons. These Counties are therefore not able to apply to be individual partnerships and must partner together, as per Table 1, p. 13 of the RFA. This is a minimum pairing. Wyoming County is permitted to make an application under this RFA in partnership with other members of the Western

New York Public Health Alliance, as long as Livingston County is also included in the application. Monroe County is permitted to make an application under this RFA either as a stand-alone partnership, or, in partnership with Livingston County, as long as Wyoming County is also included in the application. Partnerships can be comprised of any number of service areas, as long as those combinations include those listed in Table 1, and the partnership screening goal does not exceed 5,000. (Attachment 4, p. 58)

If there are no applications with an acceptable score in a given service area, or no one applies for a given service area, the Department will consider expanding an applicant's service area to include unserved counties/neighborhoods. If a contiguous area is not able to receive the award for an unserved area, the Department will consider awarding funding to another awardee to provide services in the unserved area.

41. Has the state taken into consideration in multiple county partnerships that resident diversity may differ significantly?

There is tremendous diversity throughout the state, from county to county, within counties, and within cities, towns and neighborhoods. Current contractors serve multiple counties, individual counties, neighborhoods and boroughs of New York and address the diversity through a broad and diverse base of partners and tailored recruitment plans. Please see the RFA, Section III for details about required activities related to partnership building and management and recruitment of priority populations.

42. What happens if a county that has been paired with another decides not to participate in the program? Does the other county pick up that county or does that county just not have anyone representing them or assisting clients?

Applicants applying to serve counties listed in Table 1 on page 13 of the RFA must apply to serve all counties in the county combinations and are not able to serve only one of those counties. Applicants proposing to serve a single county will not be accepted if that county is listed in a combination in Table 1. The lead (contract) agency applying on behalf of the partnership is responsible for coordinating activities throughout the entire service area. Partners should be recruited from throughout the entire service area in order to implement the required activities and carry out the intent of this RFA.

43. The lead county in a two county partnership will need to contract with another agency or Public Health Department in the other county. If the original contracting agency does not work out will the lead agency be allowed to find another agency to contract with?

Yes.

44. If only 2 awards are going to Manhattan does that mean that the NY providers would have to also serve the 1,000 - 2,000 estimated Staten Islanders or that the Staten Island provider would have to provide services for some of the estimated 5,000-6,000 NYC residents? If not, does that mean that a facility applying to serve NY could just serve Staten Island residents and the other grant recipient would have to provide services for the remaining NYC residents?

The CSP intends to award one contract to serve Richmond County (Staten Island) which is separate from any awards made to applicants proposing to serve New York County (Manhattan). Please see Attachment 4, p. 59 for the screening goal ranges for Staten Island.

45. Section II. A.1.c. Service Areas - page 13: Agencies in Queens County are specifically excluded from being able to apply for the entire county. Since we already have an existing patient base, please clarify what our responsibilities will be to those patients who reside outside of our service area. Where, for example, are they to go for rescreening? How are we to handle new patients who call from outside our service area? I have canvassed all of my hospital providers and community partners, and have learned that no other organization in Queens plans to respond to this RFA. If no one else applies, how soon after the grant award will we be advised as to how the rest of Queens County is going to be served, so that we will know how to handle these patients?

The CSP determined that up to two partnerships are needed to best serve the large estimated eligible population in Queens County. Service areas are designated for the purpose of providing recruitment and outreach activities to the priority population as well as to providers and other potential partners. Partnership service areas should be seamless to clients; partnerships can and should continue to serve any client eligible for services.

The CSP will notify all current contractors when the awards for this RFA are made. At that time, a transition plan will be developed, based on the needs within each service area. Elements of the transition plan will include, but not be limited to: transfer of data on the Indus data system, case management client transfer, provider agreements, and partnership member commitments.

46. Regarding the counties that must combine - when combined, will each county still receive separate performance measures?

At this time, the CSP intends to provide performance measure reports for each partnership. This includes a report of the percent of the annual screening goal completed in each county (Performance Measure #8, Attachment 3, page 57).

Scope of Work

47. In the case of the multiple county partnership, what is the role and responsibilities of the lead partner and the extent of those duties in oversight of the non-lead agency?

48. Is the lead organization responsible for administrative responsibilities of the full partnership?

49. What role does the state expect the lead agency to play in the assurance of timely reporting and provider reimbursement?

Lead/contracting agencies will coordinate or subcontract for coordination of the CSP partnership offering integrated, comprehensive, age-appropriate screening services for their proposed service areas. The successful agency or institution will become the contracting agency and legal entity with which the NYSDOH enters into a contract on behalf of a community-based partnership.

The lead agency is responsible for ensuring that all required activities are implemented as per the RFA and the CSP Operations Manual. The lead agency is responsible for ensuring that staff resources are sufficient and that identified staff and contractors are fully qualified to implement all required activities.

50. What functions are in place to deal with possible difficulties between partners, such as mediation or intervention by the state or an outside dispute -mediation organization? In the case of a past lead agency (who is not applying this round) not meeting or exceeding their goals, how will the state assist a new partner in correcting residual difficulties with county entities, groups and residents?

51. In light of having to make up ground from pre-existing problems of former partnerships, to what extent is the state willing to take this into consideration in providing extra support, funding or resources etc. to "clarify" information or procedures with providers or otherwise counteract any existing situation?

As per the RFA, p. 5, CSP staff provides oversight and guidance to the partnerships through programmatic and administrative technical assistance, public and healthcare provider education regarding cancer prevention and early detection, and assistance implementing effective outreach to and recruitment of the priority populations. Additionally, CSP staff work with community-based staff to ensure that individuals with abnormal screening results receive follow-up and case management as needed and that quality clinical services are provided by the partnerships through credentialing activities and a quality assurance program. Each contractor is assigned a regional technical advisor with whom the partnerships can work directly on implementation of required program activities. The NYSDOH Cancer Screening Research and Evaluation Unit (a.k.a. Data Unit)

provides data management support and monitors and assesses program data for NYSDOH staff and partnerships. (RFA, p.5-6)

The infrastructure funding amounts indicated in this RFA (Attachment 5) reflect a significant increase over past infrastructure amounts. No additional funds will be provided for correcting prior problems.

52. Section III.A.2, refers to Recruitment of the priority populations – please clarify the partnership's role in working with providers and the community relating to prostate cancer diagnostic services and no-cost HPV vaccine availability.

The lead agency coordinates, or subcontracts coordination of the partnership to implement and manage all required activities under the guidance of the CSP. A key function of partnerships is to maximize access and quality care to priority populations, facilitating referral of men diagnosed with prostate cancer by a CSP participating provider to the Medicaid Cancer Treatment Program (MCTP). Additionally, partnerships are responsible for recruiting and/or educating providers to ensure that eligible women aged 19 to 26 have access to and receive the screening tests and prevention services (HPV vaccine) for which they are eligible. Women age 19 – 26 are not the CSP priority population, however, if these women are included in the proposed screening goals, recruitment activities should also be directed towards this population.

In addition, beginning on or after April 1, 2008, pending allocation of funding and additional resources, CSP enrolled providers will be reimbursed for prostate cancer diagnostic services for eligible men. CSP credentialed clinicians providing reasonable and customary diagnostic testing and evaluation in accordance with approved clinical guidelines will be reimbursed for these services at established Medicare rates. Further guidance regarding medical guidelines for diagnostic testing and evaluation is in development and will be provided to awardees should the initiative be funded.

53. In the past Oneida County Health Department (OCHD) provided breast & cervical and St. Lukes/Faxton hospital CRC. We are now integrating our services with OCHD as lead agency and Faxton/St. Luke's subcontracting for colorectal cancer (CRC) screening. Would OCHD as the lead agency be required to provide payments for patient services directly to all providers or can the subcontractor Faxton/St.Lukes (CRC) continue to reimburse the colorectal providers for patient services.

The lead agency will be the contracting agency and legal entity with which the NYSDOH enters into a contract on behalf of a community-based partnership. The lead agency is the only agency that holds the contract with NYS and is responsible for submitting vouchers to the state. Funds will be sent only to the lead agency for disbursement.

54. Page 6. Section 2: What is meant by prostate cancer diagnostic testing and evaluation? Is there a fee schedule for these services? What services are included?

The legislation that created the Medicaid Cancer Treatment Program (MCTP) states that men diagnosed with prostate cancer through the CSP or screened or referred for prostate cancer screening through the CSP are eligible for treatment coverage. In order to ensure implementation of the legislation, as of October 1, 2007, men diagnosed with prostate cancer through providers enrolled in the CSP are eligible for treatment coverage through the MCTP. A request has been made for allocation of funding and additional resources in the 2008-2009 state budget to support reimbursement of CSP enrolled providers for prostate cancer diagnostic services for eligible men. The proposal supports CSP credentialed clinicians providing reasonable and customary diagnostic testing and evaluation in accordance with approved clinical guidelines with reimbursement for these services at established Medicare rates. Further guidance regarding medical guidelines for diagnostic testing and evaluation is in development and will be provided to awardees should the initiative be funded.

55. Page 9 Section 5: What are your Quality Assurance expectations?

These are documented in the CSP Operations Manual. Successful applicants to the RFA will be provided with additional guidance regarding quality assurance activities.

56. Section Program Management, section a, page. 19:Although full cooperation with the program's Quality Assurance team can be assumed, will the local partnership be notified of any provider whose data are cause for concern? What authority will the Partnership have to enforce "remediation" of deficiencies?

The CSP Quality Assurance team will review with the partnership and providers any data that is cause for concern. The provider agreement is the authority by which the partnership can pursue "remediation" of deficiencies.

Clarification:

RFA, p. 33, "…applicants should identify which at-home fecal test will be offered and describe how/why this was selected. Applicants should elect to exclusively use one of the available fecal tests, i.e., either FOBT or FIT. In instances where the use of the selected test poses a barrier to the participation of a provider or individual patient, the CSP will allow use of the alternative test at the request of the contractor."

The CSP encourages partnerships to select one type of fecal test to ensure continuity of education and clinical information to clients and providers. However, the CSP does allow for use of both tests by different providers within a single partnership, based on their preference and/or agreements with labs for developing the tests.

57. RFA pg. 33: Are partnerships now allowed to determine their own colorectal cancer screening test kits, FOBT or FIT kits? Or is it as was told to the partnerships in the past that we are to wait until the pilot program was complete before transitioning into using FIT kits as opposed to FOBT kits?

Partnerships will now be allowed to determine which screening kit they will use.

58. In applications with 2 or more counties applying together, where one county is currently using FIT and one county is currently using FOBT, do both counties need to use the same testing kit in the 2008-2009 application?

As clarified above, different screening fecal test kits are allowable. However, it is preferred that partnerships select one, primary test for the partnership for ease of program administration and implementation.

59. RE: Pg. 17, bullet #3, point #4 – We'd like clarity regarding the statement, "In instances where the use of the selected test poses a barrier to the participation of a provider or individual patient, consideration will be made for use of the alternative test." If we choose FIT and that test is positive, then we can enroll them for a colonoscopy. If however, we are not covering the cost of development for FOBT, what happens if the client's FOBT is positive? Will the state allow reimbursement of a colonoscopy from the FOBT if our program is using FIT? This will be vital as we look to recruit additional providers for the new RFA and grant year.

The state will reimburse a partnership for colonoscopy as a follow-up diagnostic test to both fecal tests (as per the CSP Operations Manual) regardless of the one selected by that partnership. As per the RFA, section V. Application Format and Content, the applicant should describe how it will develop and implement procedures for timely follow-up of men and women with abnormal screening

results to schedule them for appropriate diagnostic tests and report results to the CSP in a timely manner, as per the Program Performance Measures (Attachment 4) and the Operations Manual. This applies to all screening tests used.

60. What is the length of time that charts must be stored?

According to Public Health Law, 405.1, Section 4, medical records shall be retained in their original or legally reproduced form for at least 6 years from the last date of service. Partnerships must retain information, including data related information for 6 years.

61. If the lead agency changes to another contractor, who retains the <u>current</u> client records?

62. If the lead agency changes to another contractor, who is responsible for storing <u>past or inactive</u> client records?

The medical provider who holds the patient medical chart retains these charts. Any other program-related partnership records (patient, accounting, etc.) will be transferred to the new contract holder. All data forms must be entered on the Indus data system or turned over to the new partnership at the conclusion of the current contracts (March 31, 2007). Integrity and confidentiality of all records must be maintained.

The CSP will notify all current contractors when the awards for this RFA are made. At that time, a transition plan will be developed, based on the needs within each service area. Elements of the transition plan will include, but not be limited to: transfer of data on the Indus data system, case management client transfer, provider agreements, and partnership member commitments.

63. Can patient charts be housed in more than one location?

Patient medical/clinical records must be maintained in the service provider's records' office.

64. Section Screening and Diagnostic Activities, page 17: How are current contractors to make provisions for continuity of care when there is no certainty that any current contractors will continue to be funded?

This situation would occur if the applicant agency is a new contractor, is merging or proposing to cover a service area currently covered by an existing contractor, or is proposing to provide screening services currently provided by an existing contractor (e.g., the applicant currently provides colorectal cancer screening and is proposing to provide breast, cervical and colorectal cancer screening under this RFA). The applicant should include plans to provide services to clients currently seen by an existing contractor. Continuity of care is a program priority; therefore the CSP will further define the transition process once awards have been announced.

The CSP will notify all current contractors when the awards for this RFA are made. At that time, a transition plan will be developed, based on the needs within each service area. Elements of the transition plan will include, but not be limited to: transfer of data on the Indus data system, case management client transfer, provider agreements, and partnership member commitments.

65. In relation to Work plan, page 33: The RFA stipulates a requirement to provide a detailed plan for transitioning clients. How are we to handle currently enrolled clients who reside in zip codes outside of our service area? Will we be unable to provide screening to new patients who reside in zip codes outside of our service area? Will we have to deny them care?

Service areas are designated for the purpose of providing recruitment and outreach activities to the priority population as well as to providers and other potential partners. Partnership service areas should be seamless to clients; partnerships can and should continue to serve any client eligible for services.

The CSP will notify all current contractors when the awards for this RFA are made. At that time, a transition plan will be developed based on the needs within each service area. Elements of the transition plan will include, but not be limited to: transfer of data on the Indus data system, case management client transfer, provider agreements, and partnership member commitments.

66. Is a verbal agreement adequate for the doctors that will be treating HLP clients with other health issues? Page 17, IIIA2a

Signed provider agreements are required for all providers of CSP services. No such agreement is needed for those that are not providing CSP services. See RFA p.107, Attachment 14, Standard Contract, A-3. This states that a CSP provider will refer CSP clients for other health-related issues identified during the course of the provision of CSP services.

67. If a partner provider does the clinical breast exam and refers to our hospital for the mammogram, will each partner be reimbursed separately? Is there a fee schedule for each?

The State reimburses the lead agency/contract holder. The lead agency/contract holder disperses the funds to the credentialed providers who performed the services. There is a fee schedule for each of these services. Please see the CSP Operations Manual for a full reimbursement schedule.

68. [p.18, "Required activities—Develop individual care plans including periodic reassessment of client needs…"] As part of the case manager's role, what level of care planning will be required (electronic vs. paper, expected level of detail, frequency and duration for follow-up)?

This information can be found in the CSP Operations Manual. Decisions about electronic versus paper documentation are made by the applicant/partnership.

69. To confirm my interpretation of the CSP RFA - The 2 selected Bronx Partnerships would be expected to assume responsibility for covering the entire Bronx and could mean a recalculation of the expected client volume and catchment area for each chosen organization. In addition, an awarded (lead) partnership would likely need to have written agreements with additional "partnership providers" in catchment areas not traditionally served at their respective institution. And if so, the awarded (lead) partnership would be responsible for the processing of all applications, case management and accounting of reimbursements for the additional "partnership providers"?

The RFA stipulates that partnerships proposing to serve the counties of Bronx, Kings, New York, Queens and Suffolk, where multiple partnerships are allowed, should reflect screening goals of at least 30% of the range for that county identified in Attachment 4. The lead (contract) agency is responsible for coordination of all required activities, including recruiting providers throughout the proposed service area. Providers may agree to serve more than one partnership.

70. With Table 1 under c. Service Area demonstrating county combinations, will this affect pre-existing site codes for acting agencies in one of the newly formed combinations? (Also assuming the same agency gets the contract for the next 5 year block). For instance Washington county service providers have a site code starting with 57 and Warren county service providers have a site code starting with 83. With the new combination of Warren and Washington counties-how will the site codes be affected?

71. As a combined two county partnership will there still be two different site codes, one for each county? Will there be two different monthly billing reports or one combined report?

Site codes (assigned to providers of services through the CSP for the purposes of tracking credentials and entering data in the Indus data system will be assigned following notice of awards and contract initiation. Partnerships will continue to be provided with one monthly billing report (MBR).

72. Will the Cortland County Health Department be thought of as the "Supervisor" for IBCA?

73. Do we need two separate budgets? Two separate work plans? Or would we (Cortland) list IBCA as a sub contractor?

Lead agencies may submit only one application per partnership. Applications should conform to the format and content prescribed in the RFA (Section V, pp.

30-38). The successful agency or institution will become the contracting agency and legal entity with which the NYSDOH enters into a contract on behalf of a community-based partnership. Where the partnership's proposed service area combines two or more counties, there should be one lead agency, one budget, one work plan, etc. Applicants should ensure staff resources are sufficient and that identified staff and contractors are fully qualified to implement all required activities. Decisions about how to fulfill the RFA requirements to best serve the proposed service areas are made at the local level, by the lead agency/partnership.

74. Is it possible for joint (or dual) lead partnership, where (in the case of a two county partnership) the two counties share leadership?

No. A single organization must hold the contract on behalf of the partnership.

Clarification:

P. 33, Section V. Completing the Application A. Application Content, 6. Work Plan, Bullet #4, (asks the applicant to): Describe plans to implement screening and diagnostic services, including the following: recall patients for rescreening at recommended intervals, including those recently enrolled in public insurance programs.

The partnership's responsibility is to refer clients to facilitated enrollers for potential enrollment in public insurance programs and follow up to encourage people to enroll. Processes for implementation are in development and will be included in updates to successful applicants (p. 19, Section III). The partnership will not be responsible for establishing a separate or specific recall process for screening clients ultimately enrolled in public insurance programs. Any client receiving program screening services must be entered into the Indus data system (the CSP's on-line data system) and provided with recalls for rescreening services, even if they enroll in public insurance programs.

Public Insurance Programs

75. RE: Pg. 17, bullet #3, point #2 – Currently, if clients are enrolled in Medicaid or FHP (Family Health Plus), then they are ineligible for enrollment in the CSP. Why, and then how, are we to track them for recall since they won't be a client of ours on INDUS?

The partnership's responsibility is to refer clients to facilitated enrollers for potential enrollment in public insurance programs and follow up to encourage people to enroll. Clients provided with partnership services who are referred to facilitated enrollers may become eligible for public insurance, however, the enrollment process, determination of eligibility and insurance coverage does not take place immediately. These clients are entered into the Indus data system.

Clients cannot be removed from the Indus data system solely because they have been given a referral to a facilitated enroller. These clients should be provided with the same rescreening services as all other clients. If, at the time of recall, the client is found to be enrolled in a public insurance program, s/he should be "dispositioned" out of the Indus data system.

76. Will INDUS have a specific Recall List for the facilitated enrolled clients that a Partnership has referred to the enrollers (thus the Partnership has no financial responsibility to them)? Page 19, IIIA5a

No. The responsibility of partnerships is to refer clients to facilitated enrollers for potential enrollment into public insurance programs and follow up to encourage people to enroll. If these clients receive CSP services, they should be entered on the Indus data system. Tracking for rescreening procedures in place for all clients apply to them as well.

77. The RFA stipulates recalling of individuals who are "recently enrolled in public insurance programs?"

- **Will this be part of the recall through Indus? If not, how will this be tracked?**
- **What allows us to access this information from public insurance programs?**

As noted above, the responsibility of partnerships is to refer clients to facilitated enrollers for potential enrollment into public insurance programs and follow up to encourage people to enroll. If these clients receive CSP services, they should be entered on the Indus data system. Tracking for rescreening procedures in place for all clients apply to them as well.

78. [p. 19, "Implement reciprocal referral system…"] in regards to the facilitated enrollment responsibility, does this refer to implementation of a referral system that is forthcoming, or will the development of such a system be an expectation?

This statement refers to a referral system that is forthcoming. As stated in the RFA, p. 19, processes for implementation are in development and will be included in updates to successful applicants. However, applicants are also asked to include a description of how they will insure implementation of the referral system in their application (RFA, p. 32, V.A.5, 5th bullet).

79. Since there is such a strong emphasis on enrollment into Medicaid and Family Health Plus, are you looking for mention in our work plans to have someone in the program trained as a Medicaid Facilitated Enroller?

80. Again, P.1, last bullet under "Purpose", please clarify the role of these proposed CSP Partnerships in enrolling low income persons into Medicaid, Family Health Plus or other public insurance programs. Currently this role

is filled by financial counselors at provider sites, such as hospitals. Is it the intent of the CSP that this role now be undertaken by local Partnership staff?

It is not the intent that local partnership staff becomes facilitated enrollers. Applicants are not required to include training of program staff as facilitated enrollers in the work plans. Applicants are asked to include a description of how they will insure implementation of the referral system in the technical proposal section of their application (RFA, p. 32, V.A.5, 5th bullet).

81. Section Program Management, section a, page 19: Regarding the stipulation to "implement reciprocal referral system whereby CSP partnership clients are referred to Medicaid, Family Health Plus or other public insurance programs," will the CSP establish a reciprocal referral agreement for the state insurance programs as well as the processes for implementation that are in development? Or will local partnerships be expected to establish agreements with local agencies administering enrollment in state insurance programs?

Local partnerships will be expected to establish agreements with local agencies administering enrollment in public insurance programs. Applicants are asked to include a description of how they will insure implementation of the referral system in their application (RFA, p. 32, V.A.5, 5th bullet).

82. Re: Public insurance programs page 10: If the focus of the CSP Partnership programs is on the uninsured and underinsured, what proportion of infrastructure funding is intended to support those who are currently insured or who may qualify for insurance? How will the recall of these clients be managed?

The infrastructure funding amounts indicated in this RFA (Attachment 5) reflect a significant increase over past infrastructure amounts. Infrastructure amounts support the base costs necessary for implementing the required partnership activities (Section III., 1. partnership building and management, recruitment of priority populations, screening and diagnostic activities, case management, and program management) for screening goal ranges and the public health initiatives of HPV vaccine administration, referral to public insurance programs and follow up to encourage people to enroll, and enrollment of men diagnosed with prostate cancer in the Medicaid Cancer Treatment Program.

The responsibility of partnerships is to refer clients to facilitated enrollers for potential enrollment into public insurance programs and follow up to encourage people to enroll. If these clients receive CSP services, they should be entered on the Indus data system. Tracking for rescreening procedures in place for all clients apply to them as well.

83. What is the degree of involvement in referring to other insurance programs? Why is this included in rescreen protocols? (Pages 10/11)

84. Please clarify procedures for linkage with facilitated enrollers and length of follow-up for continued recall of insured. (p.11)

The responsibility of partnerships is to refer clients to facilitated enrollers for potential enrollment into public insurance programs and follow up to encourage people to enroll. If these clients are provided CSP services, they are entered on the Indus data system and all tracking for rescreening procedures in place for all clients apply. If, at the time of recall, the client is found to be enrolled in a public insurance program, s/he should be "dispositioned" out of the Indus data system. This helps to insure continuity of care for all clients.

85. Section Screening and Diagnostic Activities, page 17: It is stated that the recalling of previously screened persons is to include those recently enrolled in public insurance programs. Is it valid to assume that once the recall notification has been sent, that those individuals may then be deleted from the partnership rosters (and therefore from the rescreen performance measures)? Please confirm.

Clients may be removed from the partnership rosters only when it is confirmed that the client is sufficiently insured and no longer eligible for the CSP.

86. Why is there not a performance measure for facilitated enrollment?

No performance measures were developed for the public health initiatives - HPV vaccine administration, referral to facilitated enrollers for public insurance, and enrollment of men screened/diagnosed with prostate cancer in the Medicaid Cancer Treatment Program – to allow for any needed programmatic revisions after the first year of implementation.

87. How important is facilitated enrollment going to be stressed?

Enrollment of insurance is a priority goal of the Department's programs. There is no performance measure at this time for implementation of referrals to facilitated enrollers to allow for any needed programmatic revisions after the first year of implementation. Please note that applicants are asked to include a description of how they will insure implementation of the referral system in their application (RFA, p. 32, V.A.5, 5th bullet).

88. Will INDUS be changed to say "enrolled through facilitated enrollment" through the rescreening disposition to give credit to partnerships?

The current "no longer eligible" category should be used if a client is confirmed to be insured. Activity in this category will be monitored to evaluate needed changes to the Indus data system.

Key Staff and Functions

89. If a Partnership Coordinator is considered fulltime employee at 37.5 hours per week (.938 FTE) and spends 18.75 hours (.469 FTE) as coordinator for one county and 18.75 hours for another county, because the agency administrates two cancer service program partnerships- does this fulfill the requirement outlined in ii of 8a. Personnel in Budget and Justification (page 35) of having the Program Coordinator work a minimum of 50% FTE (versus 50% of the position hours). Please answer if it is acceptable to have a full time Partnership Coordinator position divide time between more than one cancer service program partnership. Also asking if Partnership Coordinator position must be hired at least 20 hours/week to fulfill a 50% FTE. Does this prevent a partnership coordinator having two or more roles in a cancer services program partnership?

It is not advisable, but is acceptable to have a full time Partnership Coordinator divide time between more than one CSP partnership if the Coordinator works a minimum of 50% FTE directly on each project. 1 FTE can equal 37.5 to 40 hours, as defined by the institution(s). A Partnership Coordinator can have more than one role in a CSP partnership as long as s/he is working a minimum 50% FTE directly on the project as the Coordinator. Note that applicants define the service area and are able to combine service areas, as long as the minimum required county pairings listed in Table 1, page 13 are maintained.

90. Section III.B.1, refers to Key Staff and Functions – The RFA states that the Partnership Coordinator should be at least a 50% FTE – If a subcontract is established to serve one of the two counties, a part time coordinator employed by the subcontracting agency will be beneficial. Can this 50% FTE requirement be split among the lead agency and the subcontracting agency?

91. On page 20 B. Key Staff and Functions, 1. Partnership Coordination –The Coordinator should be at least a 50% FTE. Can this 50% FTE be divided between two staff (one at lead agency and one at another agency, i.e. one per county health department for multi- county application)?

92. This RFA requires the Coordinator be @ least 50% FTE. I would assume that the Coordinator would be responsible to Coordinate all services Breast, cervical, colorectal & prostate. Is this correct? At the present time we have 2 coordinators, could they continue to share the responsibility.

93. With a collaborative venture between our two counties, can we have co-coordinators?

As stated in the RFA, p. 20, the Partnership Coordinator serves as the point of contact for all general, contractual and financial communication between the CSP and the partnership. One Partnership Coordinator should be designated and it is recommended that the lead agency (contractor) employ this individual. The partnership should ensure that the percentage of time designated for the Coordinator is commensurate with the partnership's screening volume. The

Coordinator should be at least a 50% FTE. The 50% FTE requirement cannot be split among agencies. Note that applicants define the service area and are able to combine service areas, as long as the minimum required county pairings listed in Table 1, page 13 are maintained.

94. In a small subset such as Essex and Franklin Counties is 50% of the coordinator's time unrealistic? Shouldn't we find out what percentage has been worked by the coordinator and base this time on the true needs of the partnerships?

An assessment of the needs related to implementing successful partnerships in order to meet and exceed the newly defined screening goals, performance measures and public health initiatives was conducted by the CSP. The results are provided in Section III.B. Key Staff and Functions. Based on this assessment, the CSP determined that the Partnership Coordinator should be at least a 50% FTE directly on the project.

95. Section III.B.3, refers to Data Management – If the lead agency performs data management activities, can a subcontractor also have access to INDUS in order to determine follow up for clients?

Yes.

96. Can there be more than one data manager? If not, should we list one data manager (as the point of contact for all data related questions) and then the rest as assistant data managers (in large partnerships we have a few people entering the data)?

Yes, there can be more than one data manager. There are no requirements for specific personnel titles related to data management; staff should be sufficient to implement the required activities and data management functions (RFA, p. 21). Proposed personnel should be consistent with the proposed screening goal.

97. Question refers to Section C, page 6: Since the CSP does not support any screening for prostate cancer, what will the SIF (Screening Intake Form) and FUF (Follow Up Form) for prostate patients include? Do the data on these men have to be entered into INDUS before application is made on their behalf for the Medicaid Treatment Act? Whose responsibility will it be to enter these data?

At present, data will be entered using the prostate cancer encounter form. As stated in the RFA, p. 34, during the first grant year, prostate services provided through the CSP will be evaluated. Because the CSP does not endorse population-based prostate cancer screening, there is no goal for prostate services, nor should a male with suspected prostate cancer be counted in the required percentage of males served, unless that person also has a colorectal cancer

screening. For year one of the grant, data input for prostate cancer diagnostic services (from faxed hard copy provider forms) will be the responsibility of CSP staff, not partnership staff.

98. Will the INDUS system be integrated with the new contract year?

Yes. The Indus data system (the CSP's statewide data collection system) will be integrated so that services for breast, cervical and colorectal cancer will be accessed on one system. The user will log on to one site and not two separate sites.

99. Page 18 Section 4 What are the specific qualifications for staff case managers? As the lead agency are we responsible for the care plan? Or does each agency do care plans for their own clients?

The applicant must describe the staffing patterns and plans needed to implement the required case management activities and functions, as described in the RFA, Section III, pp. 18, 21-22. Partnership members (partners) may be a source of assistance in developing these plans and implementing agreements to provide case management. Please refer to the CSP Operations Manual for more information about case management qualifications.

Performance Measures

Clarification:

Note that successful awardees will be provided with the precise calculations and definitions of performance measures. Many of the performance measures presented in the RFA are based on indicators used by the Centers for Disease Control and Prevention (CDC) to measure the implementation of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) by the CSP. It is anticipated that the CDC will revise the NBCCEDP performance measures. The CSP may revise partnership performance measures throughout the grant period so that they are consistent with the CDC measures and enable the CSP to best monitor new initiatives and address performance issues.

100. What will the definitions and calculations be for the 19 performance measures? (Page 57)

See box above.

101. Performance Measure #4: Since this is a colorectal cancer screening indicator, is it a correct interpretation to say that the expectation is for 20% or more of the clients screened for colorectal cancer will be men, not that 20% of all clients screened through the program will be men?

No. The performance measure goal is that ≥ 20% of all clients screened through the program will be males. Most of the men screened in the program will be screened for colorectal cancer (males may be screened for breast cancer, as per the CSP Operations Manual).

102. Performance Measure #6 This is an integrated screening indicator which reads that the % of clients age 50-64 will be equal to or exceed 75%. In light of the state average for mammogram clients age 50 or over being only about 50%, this seems to be a significant change to expect in one year. In communities with broad awareness and use of the program by individuals under age 50, the total program could have to increase by 50% to 100% in order to meet the percentage requirements and still be able to rescreen their current population. Is it acceptable, therefore, for a program to lay out a plan to attain this goal by the end of the grant period, rather than in the first year?

The priority population is women ages 50-64. A program can lay out a plan to reach this goal by the end of grant period, however, all partnerships will be evaluated on this performance measure throughout the contract year.

103. If an applicant's annual screening goal includes eligible women 18-39 years of age (pg 12." ..screening goal may include estimates of eligible women…18 to 39 years of age") consistent with provision of HPV vaccine and related screenings, this seems to undermine the ability to meet performance measure #6, as discussed above. If an applicant does not include women 18-39 in their screening goal, would any women subsequently served not be included in any calculations toward performance measures – neither toward screening goal or in the client total related to performance measure #6?

All women screened are included in the denominator for this performance measure.

104. Performance Measure #7 This integrated screening goal requires that 50% of women age 50+ will receive comprehensive screening. Will women be counted as having received comprehensive screening, as indicated for their history, who are not in need of /eligible for one or more screenings (e.g. had a colonoscopy, have had 3 negative Paps in a row, have had a hysterectomy)?

Eligibility for screening services will be taken into account with the calculation of this performance measure.

105. Please clarify Program Performance Measure #7 (p. 57)

- **Define "comprehensive"…**
- **Is it all 4 services (CBE, Mammo, Pap, Colorectal)?**
- **Or a combination of a certain number of the services?**
- **Do they all need to be all CSP paid or Other funds too?**
- **What if woman is not eligible for all services?**
- **Does the 50% goal refer to 50% of all 50+ in program?**

Comprehensive screening is the provision of appropriate screening services (breast, cervical and colorectal) to eligible men and women, as per the CSP Operations Manual. Performance measure #7 is a measure of the percent of eligible women age 50 and older provided with all of the screenings (breast, cervical and/or colorectal) for which they are eligible through the program. This may include screening for one, two or all three of the cancers addressed by the CSP, depending on eligibility. The services do not all need to be CSP-funded. Eligibility will be taken into account with this performance measure. The 50% goal refers to 50% of all program-eligible women age 50 and older.

106. Performance Measures #8 & #9 These are integrated screening indicators related to setting an annual screening goal and meeting that goal (#8), and whether that goal achieves screening 20% of the eligible population (#9).

107. Please clarify Program Performance Measure #9 (p. 57)

- **Define "eligible population screened"**
- **If the annual screening goals are based on 20% of the eligible population, how does this PM differ from #8?**

These are measures of the ability to reach the proposed screening goal with comprehensive, age appropriate screening of eligible men and women. Current eligibility for screening tests and prevention services by gender and age is defined in the RFA on p. 10 and clarified in detail in the CSP Operations Manual. Performance measure #9 refers to the proportion of the eligible population in the proposed service area screened through the partnership as a whole. Performance measure #8 refers to the proportion of the proposed screening goal achieved within each county in the proposed service area and is calculated for each county served by the partnership.

108. The screening goal ranges in Attachment 4 are stated to be based on an estimate of the 'eligible priority population' in each county and that the screening goal is approximately 20% of the estimated 'eligible priority population'. This eligible priority population is stated as including women 40 or older and men 50 or older. Does this table of Number of People to be Screened reflect the goal of 20% of 'eligible population screened' as required in performance measure #9? If not, is the 'eligible population', determined by the applicant or by the CSP? If it is determined by the CSP, is that number available by county?

Yes, Attachment 4 reflects the goal of 20% of the eligible population screened, as required in performance measure #9. These estimates are listed by county. Instructions for selecting a screening goal using Attachment 4 are provided in the RFA, p. 32.

109. Please expand on Program Performance measure # 10 –Cervical Cancer Diagnostic % abnormal cervical screens followed up within 60 days. Will this include the entire population of age 18 to 64 females who have abnormal cervical screen? Is it following the target population of age 50 to 64?

This performance measure includes the entire population of age 18 to 64 females who have abnormal cervical screenings. All clients must be provided with follow-up, as per the CSP Operations Manual.

110. We have a two county service area. Will goal achievement be separated by county or combined? Will other performance measures be separated by county or combined?

At this time, the CSP intends to provide performance measure reports for each partnership as a whole. Performance measure #8 is the exception, it will be reported to the partnership by county as it is a measure of the annual screening goal completed in each county in the proposed service area/partnership (Performance Measure #8, Attachment 3, page 57).

111. Will data reports be separated by county? If not, can county specific queries be made to obtain data?

At this time, the CSP intends to provide performance measure reports for each partnership, as a whole. Performance #8 is the exception, it will be reported to the partnership by county as it is a measure of the annual screening goal completed in each county in the proposed service area/partnership (Performance Measure #8, Attachment 3, page 57). Other queries are not available at this time.

112. Can we disposition clients for each category? (Page 57)

113. In relation to Performance Measures, page 57: It is assumed that the Screening Intake Form (SIF) will now include an area for colorectal cancer screening. Will there be a place to document a situation in which a woman has already had a screening colonoscopy in the last two years, and is therefore not eligible for FOBT? (Uninsured persons in New York City are eligible for free colonoscopy through the City Council colonoscopy program.)

The Indus data system will provide fields to indicate if a client is not eligible for screening for individual cancer types. The Screening Intake Form (SIF) will include an area for colorectal cancer.

114. Performance Measures - page 57 - Please clarify why "% of grant funds expended" is considered a performance measure.

This is a measure of the partnership's ability to successfully implement required program management fiscal activities and is consistent with the standards by which the CDC evaluates the CSP.

Terms of Contracts, Payment and Reporting Requirements

115. If the contracts and budgets that are anticipated to be in place by April 1, 2008 are not ready or not accessible to the lead agencies applying for 2008-2013 contracts, how is the lead agency and it's subcontractor(s) expected to get started? Delayed funding will potentially hinder the hiring of new staff, continuing consistent care and being able to meet goal numbers.

116. Continuity of Care: Assuming that the contract and budget for the newly awarded partnerships are NOT in place and available by April 1, 2008 and a lead agency is responsible for a new county that they have not served before, who will be responsible to provide the services of the program (i.e. ensuring paperwork-Screening Intake Forms (SIF) and Follow-Up Forms (FUF) are submitted, receiving Monthly Billing Reports (MBR), paying providers for completed services, offering case management services, etc.)? The new lead agency will not yet have the legal ability to do so and the previous lead agency's contract will have expired and they may not be willing to ask for an extension.

117. Should existing partnerships, in counties which have been combined, stop screening on March 31, 2008, until the new grant is awarded? Especially the agencies/counties who are not applying as lead agency for the 2008-2009 grants?

It is expected that the New York State contract to support infrastructure resulting from this RFA will be in effect from April 1, 2008 through March 31, 2009, with budgets and work plans renewed annually through March 31, 2013, contingent on available funds, acceptable performance and compliance with all contract requirements. Current contracts for CSP partnerships end on March 31, 2008. Successful applicants (lead/contracting agencies) will coordinate or subcontract for coordination of the CSP partnership for their proposed service area and will offer integrated, comprehensive, age-appropriate screening services upon initiation of the contract. Continuity of care is a program priority; therefore the CSP will define the transition process once awards have been announced.

The CSP will notify all current contractors when the awards for this RFA are made. At that time, a transition plan will be developed, based on the needs within each service area. Elements of the transition plan will include, but not be limited to: transfer of data on the Indus data system, case management client transfer, provider agreements, and partnership member commitments.

118. If a current lead agency is not planning to apply and will no longer be participating in the Cancer Services Program and had purchased equipment, computers, office furniture, etc. with the program funds, do these things belong to the site or to the Cancer Services Program serving that county?

These items belong to New York State. The CSP may request they be transferred to the lead agency awarded the contract for that county.

119. What happens to those organizations currently enrolled in a partnership come April 1, 2008? Assume these organizations would then need to apply to one of the awarded "lead" partnerships to continue their program. What would be the process?

Development and maintenance of the partnership is the responsibility of the lead (contracting) agency and is done at the local level. Current partners should be in touch with the lead agency to be informed of plans to apply for this RFA. Once the awards are announced, partners wishing to continue with the successful awardees may contact them about participation. Continuity of care is a program priority, and therefore the CSP will define the transition process once awards have been made.

The CSP will notify all current contractors when the awards for this RFA are made. At that time, a transition plan will be developed, based on the needs within each service area. Elements of the transition plan will include, but not be limited to: transfer of data on the Indus data system, case management client transfer, provider agreements, and partnership member commitments.

120. When there is a multi-county partnership with one lead agency for all involved counties, how will the clinical reimbursement piece work? Will the reimbursement go to the county in which the patient resides, or to the lead agency?

The contract holder receives the reimbursement and disperses funds to partners.

121. Is the lead agency responsible for paying infrastructure expenses to subcontractors/partners prior to submitting vouchers or is the cost incurred by the subcontractor/partner (i.e. for salaries) sufficient? (Page 26)

Either method is acceptable.

122. How are clinical expenses divided between state and federal vouchers? (Page 26)

Data is entered into the Indus data system. The system automatically assigns payment to federal or state funds based on a predetermined formula.

123. How will the five-year NYS contract to support reimbursement for clinical services noted under 2. Funding in Section 1 be set up for contracting agencies? Will there be a one time amount that if the contracting agency "uses up" that it can be supplemented/added to (without an amendment)?

The contract to support clinical services reimbursement will be established with the anticipated five year amount, based on the agreed upon screening goal. This contract will be reviewed annually by the CSP to determine if supplemental funding needs to be added through a standard contract amendment.

124. Please clarify the differences between the three contracts.

Awards will be made to support both infrastructure and reimbursement for clinical services provided to eligible men and women through three separate contracts, as follows:

- One New York State contract to support infrastructure for a one-year period, renewed annually for up to five years
- A second, five-year New York State contract to support reimbursement for clinical services, and
- A separate, third contract with Health Research, Inc. (HRI) for reimbursement of clinical services, renewable annually over a five-year period. (HRI is a not-for-profit corporation affiliated with the NYSDOH whose mission is to independently assist NYSDOH to effectively evaluate, solicit, and administer external financial support for NYSDOH projects.)

125. With infrastructure money being based on target numbers, if a cancer service program partnership exceeds the proposed target number, will the infrastructure monies increase in the next one-year contract for infrastructure?

Future infrastructure funding will be based in part on each grantee's performance with respect to objective measures as outlined in the Program Performance Measures (RFA, Attachment 3). While year one infrastructure funding is based primarily on the proposed number of the eligible population to be screened by the partnership, it does take into account key performance measures. Infrastructure funding in years 2, 3, 4, and 5 of this grant will also be based, in part, on how well partnerships perform on these performance measures in the previous year. Partnerships that meet or exceed all of the performance measures will be best positioned to receive the maximum infrastructure for the subsequent year/s.

126. Will the Infrastructure funding range increase accordingly if the demonstrated numbers of screening goals on page 60 of the RFA #0707301113 have exceeded the goals stated in the RFA?

127. If we exceed the screening goal that we propose, will we be able to claim additional funding?

128. What mechanism is in place in increasing their funding should the non-lead partner exceed their county screening goals?

Infrastructure funding for each contract year is established at the outset of the contract for that year. Contractors that exceed their screening goal do not receive extra infrastructure funds in that given year. Clinical reimbursement funds may be increased to support increases in screening and diagnostic services.

129. In relation to Technical proposal, page 32: The RFA requires including a strategy for increasing the screening goals over the five years of the grant period. For Partnerships that are already at the maximum infrastructure level, will any additional infrastructure dollars be made available if the screening levels are increased?

The intent is to award infrastructure funding in subsequent years based on prior year's performance. Infrastructure funding in subsequent years is dependent on state budget allocations.

130. There is a range in the number of people to be served for each county. What happens if you build your plan and budget around the higher numbers, and then don't reach them?

Screening goals and infrastructure funding calculations for subsequent grant years will be based on the contractor's ability to serve the agreed upon number of clients (screening goal) and related performance measures in the current year. If a contractor does not meet the year one goals, the goal for year two may be reduced, resulting in lower infrastructure funding.

131. With the addition of HPV and the prostate cancer Medicaid treatment act, will additional funds be added for infrastructure to reach these populations?

The infrastructure funding amounts indicated in this RFA (Attachment 5) reflect the base costs necessary for implementing the required partnership activities (Section III. Scope of Work – 1. partnership building and management, recruitment of priority populations, screening and diagnostic activities, case management, and program management) for screening goal ranges and the public health initiatives of HPV vaccine administration, referral to public insurance programs and follow up to encourage enrollment, and enrollment of men screened/diagnosed with prostate cancer in the Medicaid Cancer Treatment Program.

132. Section C. Program Description Re: Data Management Section, page 9: If a current contractor receives an award under this RFA, will their infrastructure funding in the first year in any way reflect their latest Performance Measures?

No.

Budget

133. RFA pg. 78: Can we now use program funds to purchase bowel preparation for colonoscopies for eligible grant patients?

134. How will goal number of colorectal cancer screenings be determined to facilitate determination of supply and development costs? Will kit purchase remain an infrastructure cost and kit development covered by clinical service money?

While there is no kit purchase cost for FIT kits, there is a purchase cost for FOBT kits. Infrastructure budgets can include funds for the purchase of FOBT kits and kit development will be covered by the clinical services reimbursement contracts. Infrastructure budgets can also include the cost of bowel preparation supplies for men and women who will receive colonoscopies. There are a number of options for bowel preparation and they are prescribed by the clinician. Applicants are therefore discouraged from pre-purchasing bowel preparation kits.

The screening goal represents the total number of individuals provided with any type of breast, cervical and/or colorectal cancer screening through the program. Applicants should estimate the number of expected colorectal cancer screenings to be provided, using their proposed screening goal. For example, if an applicant's screening goal is 500, they might anticipate that 80% of those 500 individuals would be eligible for colorectal cancer screening and would therefore include the cost to purchase 400 kits in the infrastructure budget.

135. Under Section C – Non-Allowable Costs on page 36, it states "indirect or administrative lines will not be accepted as OTPS budget lines." "Individual itemized budget lines related to these costs (ie, rent, utilities, telephone) will be allowed with appropriate justification." Can we allocate line items under the Personnel section of the budget for staff that allocate time for the overall operation of the agency that are needed to operate the program such as the Human Resources Manager, Accounting, Payroll and the Information Systems Department because they are vital to our program's and staff's success. The OCO, Inc. Health Division is one of seven service divisions of OCO, Inc. and each division is responsible for paying a 8% federally approved indirect cost from each funding source to operate the daily needed administrative costs associated with each program or funding source.

Yes, applicants can allocate line items under the personnel section of the budget for staff that allocate time for the overall operation of the agency that are needed to operate this program. Note that the Partnership Coordinator should work a minimum of 50% FTE directly on this project. All other personnel to be paid from this grant should work a minimum of 20% FTE directly on the partnership activities. (RFA p. 35) If the personnel do not meet these requirements, they cannot be charged to this grant and must be listed as in-kind.

136. Can we have different salaries for the same position for county specific reasons (union rates apply in one case)?

Yes.

137. Should the budget reflect just the first year or should we submit budgets for each of the five years? (Page 35)

The budget and budget justification should cover the one year period from April 1, 2008 through March 31, 2009.

138. If we are subcontracting with a partner for some personnel costs, should that portion appear under OTPS/Subcontract or under Personnel?

It should appear under the OTPS/Subcontract.

139. Can you buy equipment (i.e. computer) with State money?

Yes, with appropriate justification. Expenditures will not be allowed for the purchase of major pieces of depreciable equipment (although limited computer/printing equipment may be considered) or remodeling or structural modifications.

140. If a person holds the responsibility of say the data manager for example, but goes by a different title, should data manager be listed on the budget and justification, or can it be listed in parenthesis in the budget justification?

The position title should relate to the key staff and functions needed to implement all required activities of this RFA. The person's actual title may be included in parentheses in the budget justification, but the budget should clearly list the key staff/function to be filled by this person.

141. Attachment 11. Section B Other than Personnel Services, refers to Match Requirement - Can the difference between a provider's rate per service and the CSP reimbursement rate be considered match contribution?

No.

142. Can the cost of the thin preps be placed under OTPS supply costs?

There is no supply cost associated with cervical cancer screening. Laboratories provide supplies for cervical cancer screening to providers upon request.

Performance Measure Withhold

143. Will each Cancer Services Program Partnership need to do a minimum of 2 budget modifications each year to direct the "performance measure withhold" monies?

Contractors must submit a budget modification to access performance measure withhold funds approved for release. The awardee determines the number of amendments to submit to access these funds.

144. Please expand on how performance measures "will be compared to established program standards" for numbers 4,7,10,11,12 on attachment 3. Does this mean if a CSP partnership does not meet the 75% goal for % abnormal fecal tests followed up within 60 days that 2% of infrastructure money (after first and third quarter) will not be freed up for distribution? My concern is if a CSP partnership has a population that can not have a colonoscopy for a positive fecal kit due to circumstances very difficult, or out of case management control (mental health issues, hospitalized for other health emergencies, unable to arrange transportation in a 60 day window) there is no real ability to meet this 75% goal especially the smaller colorectal screening numbers who might have only 4 positive fecal kits a year and if 2 of these 4 have circumstances preventing a colonoscopy in 60 days-then can not reach this goal.

Yes, under this scenario, 2% of infrastructure money (after the first and third quarters) would not be released for distribution.

145. In regards to the 10% withholding based on successfully meeting the performance goals #10, #11 and #12, described on pages 37 & 57 of the RFA, if the partnerships can prove that the standard of care that grant clients are receiving is comparable to non-grant, insured patients, and/or if grant patients are scheduled within the timeframe outlined in the performance measures but provider sites are unable or unwilling to accommodate these needs specifically for grant patients, reluctant to offer special privileges to grant clients that the rest of their patient base is not privy to by scheduling grant clients for procedures ahead of all other patients in order to satisfy the program criteria, will this be taken into consideration or are the 1% funds based strictly on follow-up services being *completed* within the 60 day time frame?

Yes, the 1% of funds is based strictly on the 60 day time frame. Follow-up in 60 days is the standard of care.

146. In the "Performance Measure Withhold", if the measure is not met in the first quarter and is met in the third quarter (thus meeting the first quarter at a later date), will the first 5% also be released to Partnership or? Page 36, V8e

No. Infrastructure funds not awarded based on the first quarter performance will not be available for release in the future.

147. RFA pg. 37: "Each measure that meets or exceeds the established standard will result in a release of 1% of the performance standard withhold amount." How is the performance standard calculated for the release of this 1%? Will all the performance measures in all the counties within a partnership be averaged together?

148. Will multiple county applications need to meet a combined screening goal, individual county goal or both to receive the "Performance Measure Withhold" (10% of the total budget)?

Four (4) weeks following the close of the first and third quarters, five (5) performance measures related to comprehensive screening and timeliness of follow-up will be compared to established program standards (Numbers 4, 7, 10, 11, and 12 on Attachment 3: Program Performance Measures). Each measure that meets or exceeds the established standard will result in a release of 1% of the performance standard withhold amount. The five performance measures are as follows:
#4: % of male clients >= 20% (of the screening goal)
#7: % of eligible women ages 50 and older with comprehensive screenings (i.e., breast, cervical and colorectal) >= 50% (of the screening goal)
#10: % abnormal cervical screens followed up within 60 days >= 75%
#11: % abnormal breast screens followed up within 60 days >=75%
#12: % abnormal fecal tests followed up within 60 days >=75%

These performance measures are for the partnership as a whole, not for individual counties within each partnership.

149. If/when performance measures are met and a withhold amount is released, are there restrictions as to where in the budget this may be placed? (i.e. could it be added into supplies?)

Withhold funds released may be transferred to any existing OTPS line or a new budget line may be created. In either case, as with any budget modification, CSP approval must be secured before the funding can be spent.

150. If one or more of the performance measures are not met, then will the percentage of the money go back to the state?

Any withhold dollars remaining may be redirected by the CSP.

151. In regards to the Performance Measure Withhold – Are you looking for us to include plans in our Work plan for use of the anticipated released money?

No. Plans for these funds should be developed when the funds are released and described in a budget modification.

152. Section V.A.8, Paragraph 'e', refers to Performance Measure Withhold – When a subcontract agreement is established for recruitment and case management activities to serve a specific county, is a pay-per-performance contract with the sub-contractor allowable or recommended?

Yes, this is allowable for use of infrastructure funds in order to implement the required activities and fulfill all key staff and functions described in this RFA. Agreements with subcontractors are negotiated by the lead agency and agreed upon in advance between these parties. Pay-per-performance is not allowed for clinical services. All contractors are subject to the maximum reimbursement schedule, as provided in the CSP Operations Manual.

Application Format and Content

153. RFA pg. 34: "Letters of Collaboration (Maximum page limit: 10)" Does this mean that applicants should be submitting 10 letters of collaboration or less?

Applicants may submit as many letters as needed, not to exceed a 10 page limit, to demonstrate, "…collaboration with other community partners, as previously defined in Section I of this RFA." (p. 34, RFA)

154. Should the Contract Attestation Form be submitted after the grant has been awarded? Or should it be submitted with the application?

The Contractor Attestation Form (Attachment 1) does not need to be completed and returned with the application. However, successful applicants will be required to sign and return the Contractor Attestation Form. A contract will not be issued if the awardee fails to sign and return the Contractor Attestation Form.

155. For the medical professionals in the area, do you want a count of each doctor or by medical practice? Page 31, VA3

The number of individual providers should be included. Applicants are asked to describe the provider demographics and resources of your proposed service area, including the number of breast, cervical and colorectal cancer screening,

diagnostic and treatment providers in the area, and, specifically, the numbers of each type of provider agreeing to participate in the program (RFA, p. 31). For example, an applicant may note that there are 35 primary care physicians providing colorectal cancer screening in the proposed service area and of these, 21 will participate in the partnership.

156. RFA pg. 72: The work plan template "Measure of Effectiveness" for Goal 1 states in parenthesis "(Partnership Assessment Tool, Attachment 10)". Are applicants expected to submit this attachment (#9-Partnership Assessment Tool) with their application, as it is not included in the Summary of Application content on pg. 37? And, if so, will it be included in the 15 page limit for the work plan section?

Yes, applicants are expected to submit Attachment 9 with their application. This is noted in the Technical Proposal section of the RFA, p. 32. It is not included in the page limits for the work plan section, nor is it counted towards the overall application page limit.

157. Will multi-county applications be allowed to submit extra pages for Summary of the application (maximum 2 pages); Service area/population to be served (Maximum 5 pages); Work plan (Maximum 15 pages); and/or Letters of Collaboration (Maximum 10 pages)?

No. All applicants must follow the page limitations stated in the RFA on page 37. Points will be deducted from applications which deviate from the prescribed format.

158. Under Section V – Completing the Application on page 30 under the *content* section it states " identify the screening goal selected and describe how it was selected." Should we break down the number of breast and cervical and the number of colorectal screenings we propose to provide or just provide one overall screening goal that encompasses all screenings?

Select one screening goal for the partnership, following the instructions provided in the RFA on p. 34, #5, 4th bullet. Applicants are reminded that screening goals in this RFA differ from the current contractor screening goals in that the new screening goals in this RFA represent the total number of individuals provided with any type of breast, cervical and/or colorectal cancer screening through the program.

159. RE: Pg. 30, 3rd paragraph – We'd like to request clarity in regards to the sentence that says, "Applicants should be complete and specific when responding, and should number and letter the narrative response to correspond to each section in the order presented." In Section V, pg. 30, under 'Content', there are only numbers and bullets, not letters to refer to

when we write our proposal. There are letters to reference in the budget and justification, though. Perhaps that's what this sentence is referring to?!?.

Applicants should use the numbers corresponding to the content sections and the letters corresponding to the budget and budget justification section. Applicants are encouraged to list responses in bulleted format to correspond to the bullets listed under each number in the content section.

160. RE: Pg.33, #6, end of first paragraph, "Workplan MEASURES OF EFFECTIVENESS" – There are measures already outlined on the workplan template. But you state on pg. 33, "Measures of effectiveness should relate to performance measures where appropriate." Are the measures that are listed on the workplan forms, that you provided in the RFA, just a guide that you want us to edit and fill in numbers, or are they the actual ones to leave alone and submit as is?

Performance measures are key indicators of partnership performance and can be used to measure effectiveness of required program activities. The performance measures listed in the work plan template forms are suggested measures of effectiveness for that particular goal. Applicants should use these performance measures as stated, and may include additional measures of effectiveness where appropriate.

161. On P. 31, #3, 4th bullet, is "and the breast, cervical and colorectal cancer burden" at the end of the sentence a redundancy as it is already mentioned in the beginning of the sentence.

162. Again, on P. 31, #3, 4th bullet "current number of.....cancer screenings provided in this service area", are you referring to screenings done by the existing Partnership contractor covering that area?

Yes, this is a redundancy. Applicants are asked to determine the number of cancer cases in the proposed service area, and may also include the number of persons being screened for breast, cervical and colorectal cancer within the proposed service area, not limited to screenings conducted by the existing partnership.

163. Are resumes required for in-kind staff?

Applicants should include a resume for the Partnership Coordinator and for other key staff identified to fulfill the functions described in this RFA. Resumes for key staff provided inkind should be included.

164. Re: Attachment 9 of RFA: Do the roles listed pertain to partner names only? Should the primary partner be included in this attachment? We suspect that "Lead Agency" would apply to the primary partner and therefore, should be listed under Partner Name. Is this the case?

The Partnership Assessment Tool should clearly name all partners and their respective roles in implementing the required activities and fulfilling the key staff and functions as outlined in Section III of the RFA. The lead agency should be listed as the primary partner on this attachment.

165. On P. 32, #5, 4th bullet, "Partnerships proposing to serve the counties of ...where multiple partnerships are allowed, should reflect screening goals of at least 30% of the range for that county identified in Attachment 4." Does this mean the applicant in these specific counties can goal for 30% of the lower number listed in Attachment 4 (P. 58) for the applicant's county. For example (fictitious) , if the range was 10,001- 11,000, could the applicant's goal be exactly 30% of 10,001?

Yes.

166. Who participates on the RFA review team? (not specific names of individuals but their positions and roles with the Cancer Services Program)

Reviewers include statewide, professional staff from throughout the New York State Department of Health, Division of Chronic Disease Prevention and Adult Health.

167. In Sheri Scavone's e-mail of October 23rd (regarding contract execution), she stated that "We anticipate significant procedural changes with the 2008-2009 contracts." We would like to know what other procedural changes you anticipate for the 2008-2009 contract period, so we can determine if it will have an impact on our application.

This refers to the implementation of the new, five-year contract with New York State for clinical services reimbursement. As stated in the RFA, p. 25, ". It is the intent of the CSP to establish a State clinical services contract for the full five year grant period, expected to be from April 1, 2008 through March 31, 2013. This new, five year contract will allow the CSP to more easily assure sufficient funding for clinical services reimbursement during each annual funding cycle without the need for yearly amendments to the state clinical services reimbursement contract.", shortening the time period for reimbursement to the clinical providers.