



Department of Health

Request for Proposals

RFP # 20062

Medicaid External Quality Review and Other Activities in New York State

Issued: August 19, 2021; September 24, 2021 Redline Version

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1.0 CALENDAR OF EVENTS

RFP 20062– MEDICAID EXTERNAL QUALITY REVIEW AND OTHER ACTIVITIES IN NEW YORK STATE	
<u>EVENT</u>	<u>DATE</u>
Issuance of Request for Proposals	August 23, 2021
Deadline for Submission of Written Questions	Questions Due by September 8, 2021 at 5:00 p.m. ET
Responses to Written Questions Posted by DOH	On or About September 24, 2021 Responses Should be Posted
Deadline for Submission of Proposals	Proposals Due on Or Before October 13, 2021 at 5:00 p.m. ET
<i>Anticipated</i> Contract Start Date	August 1, 2022

2.0 OVERVIEW

This Request for Proposals is a request by the State Department of Health’s (DOH’s) Office of Quality and Patient Safety (OQPS) and Office of Health Insurance Programs (OHIP) for proposals from qualified External Quality Review Organizations (EQROs) to conduct quality of care reviews, program evaluations, quality improvement projects, and other activities regarding health-related services provided to individuals enrolled in the State Medicaid program.

2.1 Introductory Background

The State’s Medicaid population is both culturally and clinically diverse, with varied and sometimes complex clinical care needs ranging from preventive care for children and adults, perinatal care, chronic care including HIV/AIDS, behavioral health, and assistance with activities of daily living for the elderly and developmentally disabled. In the State, since the mid-1990s, Medicaid beneficiaries have been transitioning into managed care plans (MCPs). Groups that had been exempt from mandatory plan enrollment such as beneficiaries receiving Supplemental Security Income (SSI), homeless persons, persons with developmental disabilities, the mentally ill, persons living with HIV/AIDS, and others have also transitioned to MCPs if not otherwise excluded or exempted. Currently, over 4.6 million Medicaid recipients are enrolled in MCPs. Of the remaining 1.4 million enrollees who are not enrolled in Medicaid Managed Care (MMC), approximately 967,000 are dually eligible for Medicaid and Medicare, and the remaining are institutionalized or otherwise exempt and excluded from MMC. The number of recipients who are exempt and excluded will continue to decrease over the term of this contract.

The State DOH’s primary goal for the Medicaid program is to improve health care services, population health, and create cost efficiencies consistent with the goals of the Governor’s Medicaid Redesign Team (MRT) and the CMS Triple Aim goals (improving patients’ experience with care, improving the health of populations and reducing the per capita cost of health care). Objectives for the MMC program are to improve the quality of care furnished to Title XIX beneficiaries by enhancing their access to primary, preventive, and other medically necessary services.

MMC in the State is currently organized by four primary plan models: Mainstream MCPs, HIV/Special Needs Plans (HIV-SNPs), Health and Recovery Plans (HARPs) for members with significant behavioral health needs, and managed long-term care (MLTC) plans. Some of the MMC plans offer long term and/or HIV care within their benefit package. There are currently 15 MMC plans, three (3) HIV-SNPs, 13 HARPs, and 48 MLTC plans operating in the State with more anticipated.

In 1997, the State DOH received an 1115 Waiver from CMS to implement The Partnership Plan, a statewide mandatory MMC program. Currently, all 62 counties, including New York City, have implemented mandatory enrollment for some type of MMC program. As of March 2020, over 4.6 million Medicaid recipients were enrolled in Mainstream MMC, HIV-SNP, HARP or MLTC plans.

The State's Mainstream MMC program includes up to 94% of individuals eligible for full Medicaid benefits, including most eligible adults, children, and pregnant women. Other populations such as those with developmental disabilities and those dually eligible for Medicare and Medicaid, can either voluntarily enroll or are mandatorily enrolled in other types of MMC programs.

Participating health plan organizational models include Health Maintenance Organizations (HMOs) and Prepaid Health Service Plans (PHSPs). MMC benefits are comprehensive, including but not limited to the following services: inpatient and outpatient hospital, physician, pharmacy, personal care, vision, home health, adult day health care, rehabilitation, dental, orthodontics, and some behavioral health. Most enrollees are required to have a primary care practitioner (PCP) and to use network providers, with preapproval from plan or a PCP for most specialty services. Some MMC plans also offer disease management services. Eligible enrollees can also receive case management through a Health Home, a care management service model whereby all of an individual's caregivers communicate with one another with the intention that all of a patient's needs are addressed in a comprehensive manner. Please refer to the State MMC/Family Health Plus/HIV-SNP/HARP Model Contract for a list of covered services in Mainstream MMC:

http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

In the State, Medicaid recipients (and family members) living with HIV/AIDS may join an HIV-SNP or a Mainstream Medicaid plan. Members enrolled in an HIV-SNP are eligible for all the same services to which they are entitled under Mainstream Medicaid, as well as specialized services including care coordination, treatment adherence service, and HIV prevention and risk-reduction education. HIV-SNPs are responsible for coordination of all medical services; services not covered by Mainstream Medicaid that support wellness (e.g., psycho-social case management, housing, counseling, peer support, legal assistance); special programs for treatment of substance use, homelessness, and families affected by HIV/AIDS; long-term care; and hospice.

Medicaid members with significant behavioral health needs have the option of joining either a Mainstream MMC plan or a HARP. The State Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and the State DOH jointly oversee the HARPs. The benefit package for HARPs provides the medical and physical health benefits found in Mainstream MMC plans, as well as behavioral health and substance use disorder services provided by OMH and OASAS, and Home and Community-Based Supports (HCBS) services.

The State's Medicaid MLTC program is administered pursuant to Section 4403f of Article 44 of the Public Health Law. MLTC Plans offer health care benefits to help people who are chronically ill or have disabilities and who need health and long-term care services, such as home care or adult day care, to stay in their homes and communities as long as possible. The MLTC plan arranges and pays for a large selection of health and social services and provides choice and flexibility in obtaining needed services from one organization. There are three (3) basic models of MLTC plans in the State: Programs of All-Inclusive Care for the Elderly (PACE) plans implemented according to federal regulations 42 CFR 460, Medicaid Advantage Plus (MAP) plans, and partial capitation plans. For the most part, MLTC recipients are dually eligible for Medicare and Medicaid; however, enrollees MUST be "dual eligible" to enroll in a MAP. As of March 2020, there were nine (9) PACE plans, 26 partial capitation plans and nine (9) MAP Plans serving a total enrolled population of approximately 279,553 members. The three (3) MLTC model contracts can be found at:

http://www.health.ny.gov/health_care/managed_care/mltc/index.htm.

In addition to the above MLTC plans, there are four (4) MAPs that serve approximately 3,700 enrollees dually eligible for Medicaid and Medicare. These recipients are not required to need community-based long-term care services to enroll nor are these services in the benefit package. The Medicaid Advantage model contract is found at the following URL:

http://www.health.ny.gov/health_care/managed_care/docs/medicaid_advantage_model_contract.pdf

The Fully Integrated Duals Advantage Plan for Persons with Intellectual and other Developmental Disabilities (FIDA-IDD) is another MMC plan that specifically serves individuals dually eligible for Medicaid and Medicare. This plan type is overseen and managed jointly by the State DOH and the State Office for People with Developmental Disabilities (OPWDD). In addition to the Mainstream medical benefit package, the FIDA-IDD plans also provide community-based long-term care services to persons with developmental disabilities.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized the State Children's Health Insurance Program (SCHIP) under title XXI of the Social Security Act, ensuring that states continue their existing health insurance programs and expand coverage to additional low-income, uninsured children who are not eligible for Medicaid. The SCHIP program is supervised at the state level but is administered by health plans that have a contractual relationship with the State DOH. Currently, 15 health plans in the State offer a SCHIP product for a total statewide enrollment of 433,405 as of March 2020. Effective July 1, 2009, states contracting with MMC plans for delivery of care under SCHIP programs must initiate a similar program of external quality review (EQR) for their SCHIP-contracting MMC plans. Thus, many of the EQR activities to be conducted under this Contract for the MMC program will also be applied to the State's SCHIP program, entitled Child Health Plus (CHP).

In addition to the MMC plans, there are 11 plans in the State that offer a commercial managed care line of business. Four (4) of these plans currently have no publicly funded insurance lines of business while the others also offer MMC and/or CHP.

2.2 Important Information

The Bidder is required to review, and is requested to have legal counsel review, [Attachment 8](#), the State DOH Agreement as the Bidder must be willing to enter into an Agreement substantially in accordance with the terms of [Attachment 8](#) should the Bidder be selected for contract award. Please note that this RFP and the awarded Bidder's proposal will become part of the contract as Appendix B and C, respectively.

It should be noted that Appendix A of [Attachment 8](#), "Standard Clauses for New York State Contracts", contains important information related to the contract to be entered into as a result of this RFP and will be incorporated, without change or amendment, into the contract entered into between the State DOH and the successful Bidder. By submitting a response to the RFP, the Bidder agrees to comply with all the provisions of Appendix A. Note, [Attachment 7](#), the Bidder's Certifications/Acknowledgements, should be submitted and includes a statement that the Bidder accepts, without any added conditions, qualifications or exceptions, the contract terms and conditions contained in this RFP including any exhibits and attachments. It also includes a statement that the Bidder acknowledges that, should any alternative proposals or extraneous terms be submitted with the proposal, such alternate proposals or extraneous terms will not be evaluated by the State DOH.

Any qualifications or exceptions proposed by a Bidder to this RFP should be submitted in writing using the process set forth in [Section 5.2](#) (Questions) prior to the deadline for submission of written questions indicated in [Section 1.0](#) (Calendar of Events). Any amendments that the State DOH makes to the RFP as a result of questions and answers will be publicized on the State DOH web site.

2.3 Term of the Agreement

This contract term is expected to be for a period of five (5) years commencing on the date shown on the Calendar of Events in [Section 1.0](#), subject to the availability of sufficient funding, successful contractor performance, and approvals from the State Attorney General (AG) and the Office of the State Comptroller (OSC).

3.0 BIDDERS QUALIFICATIONS TO PROPOSE

3.1 Minimum Qualifications

The State DOH will accept proposals from organizations with the following types and levels of experience as a prime contractor:

- At the time of RFP issuance, the Bidder must be an organization designated by the Centers for Medicare and Medicaid Service (CMS) as a Quality Improvement Organization (QIO) or on the list of QIO-like organizations. In order to qualify, a Bidder must be recognized by CMS as a QIO and be on the QIO or QIO-like list of designated organizations as of the issuance date listed on page 1 of this RFP; and
- The Bidder **cannot** be a NYS health care facility, an association of health care facilities conducting business in NYS, or an affiliate of a NYS health care facility. The Bidder must attest that it has no conflict of interest with respect to conducting the duties and responsibilities in this RFP; and
- At the time of bid, the Bidder and any proposed subcontractors must attest that it meets the conditions for independence as defined in federal regulation at 42 CFR 438.354(c).

For the purposes of this RFP, a prime contractor is defined as one who has the contract with the owner of a project or job and has full responsibility for its completion. A prime contractor undertakes to perform a complete contract and may employ (and manage) one (1) or more subcontractors to carry out specific parts of the contract. All subcontractors must be approved by the State DOH prior to commencing work.

Failure to meet these Minimum Qualifications will result in a proposal being found non-responsive and eliminated from consideration.

4.0 SCOPE OF WORK

This Section describes the consulting services that are required to be provided by the selected Bidder. The selected Bidder must be able to provide all of these services throughout the contract term.

PLEASE NOTE: Bidders will be requested to provide responses that address all of the requirements of this RFP as part of its Technical Proposal.

The terms “bidders”, “vendors”, and “proposers” are also used interchangeably. For purposes of this RFP, the use of the terms “shall”, “must” and “will” are used interchangeably when describing the Contractor’s/Bidder’s duties.

4.1 Tasks/Deliverables

The Contractor shall complete all activities as described in the following subsections. These services are categorized under the program for which the services are required pursuant to the State’s MMC Plan Model Contracts. Additional quality review projects are listed separately. As noted in the following description, some projects will not be conducted every year.

Over the five (5)-year contract period, it is possible that changes in the health care system and emerging health issues may require modifications to the reviews described in this RFP and to the populations reviewed. For example, medical care reviews may transition from manual medical record review to a greater reliance on review of data that is available electronically as various DOH data sources mature. Workload and volume projections are based upon information available at the time of the RFP issuance and should be considered estimates to assist the Bidder in the development of its Technical Proposal and Cost Proposal. The workload and volume projections provided do not represent a commitment or guarantee of future workload or review volumes. Based on these estimated projections, each Bidder should:

- Forecast the **personal** personnel resources necessary to meet the deliverable requirements; and
- Complete an annual and startup work plan which will be incorporated into a five (5) year "schedule of deliverables" to be included in the Technical Proposal.

The State DOH may modify workload and funding levels based upon changes in State DOH priorities, and/or changes in the health care system, specifically regarding managed care enrollment which is anticipated to reduce Fee for Service (FFS) claim volume during the term of the contract. The Contractor is expected to be flexible and able to adapt to changing requirements in analytical and clinical support.

The Contractor is required to work collaboratively with the State DOH, OPWDD, OMH, OASAS, MMC plans, and providers in developing the processes used in evaluations. The Contractor is expected to attend periodic meetings with State DOH staff to discuss activities funded by this contract. These meetings may be in-person or remote and be held at least twice a year. All materials and methodologies must be approved by the State DOH prior to implementation. The Contractor is also required to participate in monthly remote project management meetings with State staff.

The Contractor will be monitored and managed by the State DOH to determine its success in implementing a robust system for conducting the contract Scope of Work set forth in this RFP. Particular attention will be paid to the following areas:

- Timely communication with the State DOH regarding issues and workplan adjustments;
- Timely implementation of system updates, fixes, and/or patches to remain in compliance with ITS Security Policies;
- Ability to work cooperatively with the State DOH including responsiveness and flexibility;
- Timely and effective performance of the reviews and activities required in the Scope of Work;
- Accurate and timely reporting of findings to the State DOH;
- Accurate and timely reporting of deliverables/recommendations to the State DOH; and
- Maintenance of secure database(s) for protected health information (PHI)/personally identifiable information (PII) needed for activities.

4.1.1 External Quality Review Activities

Federal regulations at 42 CFR Part 438, subpart E (Quality Measurement and Improvement; External Quality Review) set forth the requirements for annual external quality review (EQR) of contracted MMC plans, including Managed Care Organizations (MCOs), for a state's Medicaid program. EQR is the analysis and evaluation by an EQR organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that an MCO, or their contractors, furnish to Medicaid recipients. According to 42 CFR Part 483.2, an MCO is an entity that has, or is seeking to qualify for, a comprehensive risk contract that is 1) a federally qualified health maintenance organization (HMO) that meets the advance directives requirements of subpart I of part 489; or 2) any public or private entity that meets the advance directives requirements and is determined by the Secretary to also a.) make the services it provides to its Medicaid enrollees as accessible as those services are to other Medicaid beneficiaries within the area served by the entity and b.) meets the solvency standards of 438.116.

The State DOH has used an EQRO since 1988 to evaluate the quality of care provided to the Medicaid population. In response to the Balanced Budget Act of 1997 (BBA), CMS published regulations (in 42 CFR, Part 438, Subparts D and E) to clarify how Section 1932c of the Social Security Act is applied in MMC. CMS further published protocols for conducting external review of MMC organizations, most recently in 2020. In addition to these specified activities, the Contractor will also be expected to conduct activities including, but not limited to: 1) performing medical record reviews in MCOs, hospitals, and other providers, 2) administering additional surveys of enrollee experience, and 3) providing data processing and analytical support to the State DOH.

The Contractor will serve as the EQRO for the State's MMC program for the duration of the contract. An EQRO is an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, EQR-related activities as set forth in 42 CFR 438.358, or both. Validation means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accordance with standards for data collection and analysis. Quality, as it pertains to EQR, means the degree to which an MCO increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

The EQR process, as dictated by CMS EQR Protocols (October 2019), consists of mandatory and optional activities, as outlined below and at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>.

Mandatory Activities:

1. Validation of performance improvement projects (PIPs);
2. Validation of performance measures;
3. Review of compliance with Medicaid and Children's Health Insurance Program (CHIP) managed care regulations; and
4. Validation of network adequacy.

Optional Activities:

1. Validation of encounter data reported by the MCP;
2. Administration or validation of quality of care surveys;
3. Calculation of additional performance measures;
4. Implementation of additional PIPs;
5. Conducting focused studies of health care quality; and/or
6. Assist with the quality rating of Medicaid and CHIP MCOs.

EQR activities under this RFP will cover services offered by the State's MMC plans, as well as plans that offer the State's CHP. Some projects may also include the Medicaid FFS population or, on occasion, the commercial managed care population for comparison purposes. The Contractor will complete the activities described under mandatory activities 1-4 and optional activities 1, 2, 3, and 5. The Contractor will be required to complete these activities as described below.

In accordance with 42 CFR 438.364, the Contractor is also required to produce a detailed annual EQR Technical Report, containing at least the following information:

- A description of the way data from all EQR-related activities conducted were aggregated and analyzed and the way in which conclusions were drawn as to the timeliness, quality, and access to the care furnished by the MCO;
- For each EQR-related activity conducted, the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data;
- An assessment of each MCO's strengths and weaknesses with respect to quality, timeliness, and access to health care services furnished to Medicaid beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO
- Methodologically appropriate, comparative information about all MCOs; and
- An assessment of the degree to which each MCO has effectively addressed the quality improvement recommendations made by the EQRO during the prior year's review.

The State has operated an EQR program that is comprehensive in assuring compliance with the requirements of the mandatory and optional activities described, but also dynamic in that its contracted EQRO is utilized to ensure that the highest level of care and services are delivered through MCOs within the context of the State's progressive MMC program. Its EQRO works closely with contracted MCOs to proactively certify successful completion of quality assurance and improvement activities, including reporting quality metrics and conducting PIPs. This enhanced EQR process sometimes involves assistance in onboarding new MCOs or purveyors of new product lines into the State's MMC quality oversight program. Thus, the Scope of Work described herein for each activity describes an interactive process between the EQRO and MCO in the conduct of EQR activities. While all EQR activities have been tailored to provide the most meaningful oversight of the State's Medicaid program, they have been designed to be equivalent to the work described in the EQR Protocols developed by the U.S. Department of Health and Human Services (HHS) and CMS.

The specific Scope of Work for each component project is outlined below under the relevant activity. The completion of work by the Contractor will be compensated on a deliverable based schedule.

4.1.1.1 Validation of Performance Improvement Projects (PIPs)

According to CMS's EQR Protocols, states must require their Medicaid and CHIP MCPs to conduct PIPs that focus on both clinical and non-clinical areas each year as part of the MCP's quality assessment and performance improvement (QAPI) program, per 42 CFR Section 438.330 and 457.1240(b). A PIP is a project conducted by the MCP that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider and/or MCP/system level.

Medicaid MCOs are required to complete ongoing PIPs, either on a yearly basis or for longer periods as approved by the State DOH. The Contractor will collaborate with the State DOH on the PIP topic selection. PIPs are currently conducted by all MMC/CHIP, HIV-SNP, HARP, and MLTC plans. As new plan types are brought into the managed care program, the validation of these plans' PIPs will be an additional responsibility for the Contractor.

The Contractor will verify that the State's PIPs used sound methodology in their design, implementation, analysis and reporting. The Contractor will review the PIP design and implementation using documents provided by the MCP, which may be supplemented with interviews of MCP staff. The Contractor then will report to the State DOH on its findings from reviewing and validating the PIPs in the EQR Technical Report.

The Contractor will follow CMS's EQR Protocols for validation of PIPs:

1. Assess the PIP methodology
 - a. Selected PIP topic
 - b. PIP aim statement
 - c. Identified PIP population
 - d. Sampling method
 - e. Selected PIP variables and performance measures
 - f. Data collection procedures
 - g. Data analysis and interpretation of PIP results
 - h. Improvement strategies
 - i. Likelihood that significant and sustained improvement occurred
2. Perform overall validation and reporting of PIP results
3. Verify the PIP findings

The Contractor will use CMS's worksheets in CMS's EQR Protocols for PIP validation tools and reporting framework.

The Contractor will provide written feedback to each managed care organization (MCO) regarding their study methodology and collect updated study methodologies from the MCOs and submit these to the State DOH for approval.

Based on more than two (2) decades of experience overseeing MCO quality improvement initiatives, the State DOH believes that quality improvement is most successful when validation is ongoing throughout the execution of a given project, rather than when used as a retrospective evaluation of success. Therefore, the Contractor is responsible for an enhanced validation of all State required PIPs to coordinate and facilitate plan progress and provide training and other resources to MCOs as needed. The Contractor will conduct conference calls with each plan to discuss PIP progress and provide technical assistance. The Contractor will collect and review a PIP Update Call Summary Report prior to oversight conference calls with the MCOs. The PIP Update Call Summary Report summarizes PIP updates for periodic oversight conference calls and is submitted one week prior to the call.

While an MCO has the option to select a project topic (e.g., cancer screening, depression) of their own choosing, they have been encouraged to participate collaboratively with other MCOs in conducting their PIPs and are encouraged to participate in a statewide PIP. The Contractor will facilitate collaboration among the MCOs through meetings, conference calls and/or webinars. Reports describing previous PIP projects are available on the State DOH's website at: https://www.health.ny.gov/health_care/managed_care/reports/index.htm under the section titled "Medicaid Quality Improvement and External Quality Review."

For all PIP projects, the Contractor will collect and review draft Interim Reports from the MCOs and submit the reports with recommendations to the State DOH within 60 days of each MCO's completion of the Interim Report. The Contractor will collect and review draft Final Reports from the MCOs, provide feedback to the MCOs for improving the reports and submit the Final Reports to the State DOH within 60 days of each plan's completion of the Final Report.

The Contractor will prepare an annual summary compendium report including each MCO's PIP with an evaluation of improvement from baseline to the final results. The Contractor will organize and conduct in-person conferences, workshops or webinars to share the results and promising practices. The Contractor, in conjunction with DOH and the MCOs, may also be asked to develop and monitor quality improvement strategies related to PIP results.

4.1.1.2 Validation of Performance Measures

According to CMS's EQR Protocols, States are required to specify standard performance measures for MCOs to include in their comprehensive QAPI programs. States use performance measures to monitor the performance of individual MCPs at a point in time, to track performance over time, to compare performance among MCOs, and to inform the selection and evaluation of quality improvement activities. Each year, the MCOs must: (1) measure and report to the State the standard performance measures specified by the State; (2) submit specified data to the State which enables the State to calculate the standard performance measures; or (3) a combination of these approaches.

The State DOH will provide the Contractor with the list of performance measures to be validated along with requirements for data collection and reporting (e.g., sampling guidelines and instructions for calculating numerators and denominators). The Contractor will validate the specified performance measures for inclusion in MCOs' QAPI program. The Contractor will also assess whether the performance measures calculated by the MCO are accurate based on the measure specifications and state reporting requirements, per 42 C.F.R. § 438.330(b)(2), by conducting onsite visits to MCOs.

The Contractor will follow CMS's EQR Protocols for validation of performance measures:

1. Conduct pre-onsite visit activities
 - a. Define the scope of the validation
 - b. Assess the integrity of the MCOs information system
 - c. Conduct detailed review of measures
 - d. Initiate review of medical record data collection
 - e. Prepare for the MCO onsite visit
2. Conduct onsite visit activities MCO directory:
https://www.health.ny.gov/health_care/managed_care/plans/mcp_dir_by_plan.htm
 - a. Review information systems underlying performance measurement
 - b. Assess data integration and control for performance measure calculation
 - c. Review performance measure production
 - d. Complete the detailed review of measures
 - e. Assess the sampling process (if applicable)
 - f. Communicate preliminary findings and outstanding items
3. Conduct post-onsite visit activities
 - a. Determine preliminary validation findings for each measure
 - b. Assess and document the accuracy of performance measure reports
 - c. Submit validation report to the State DOH.

The Contractor will use CMS's worksheets in CMS's EQR Protocols for performance measure validation tools and reporting framework. Information on the CMS Protocols can be found at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf> and the CMS worksheets are located at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-worksheets-2019.zip>.

Project 1: Validation of MCO Quality Performance Measure Data

Since 1995, the State has required MCOs to report standardized measures of quality, access and utilization through an annual reporting protocol known as the Quality Assurance Reporting Requirements (QARR). This annual process primarily utilizes measures from the Healthcare Effectiveness Data and Information Set (HEDIS®) and is augmented with State-specific measures to reflect the current health issues affecting the State Medicaid population. The measures focus on preventive health services, prenatal care, acute and chronic disease, and mental health. All QARR data are self-reported by the plans. MCOs are required by the State to contract with a National Committee for Quality Assurance (NCQA)-certified audit organization for an audit of the calculation and reporting of quality measures to the State every year. The resultant standardized data set is used to evaluate plan performance in four (4) specific areas: 1) quality of care, 2) member access and satisfaction, 3) enrollment and utilization, and 4) network and clinical management. QARR submissions are required for all MCOs submitting QARR/HEDIS® data, including MMC plans, HIV-SNPs, HARPs, commercial plans including Qualified Health Plans (QHP), and the Essential Plans. The commercial plans and QHP are licensed health plans approved by the New York State of Health (NYSOH), an organized marketplace designed to help people shop for and enroll in health insurance coverage, to provide comprehensive coverage, follow limits on out-of-pocket expenses, and meet other requirements. The Essential Plans are health plans available to consumers under age 65, not eligible for Medicaid or CHIP, without access to affordable Minimal Essential Coverage, and who have income at or below 200 percent of the federal poverty level, participating in NYSOH's Health Plan Marketplace.

The Contractor will develop a submission platform that allows secure file transfer to the Contractor for all required QARR files, such as audit findings, State-specific measures, person-level detail files, birth files and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) files. The Contractor will develop a data submission tool to collect State-specific measures and revise the tool annually as needed. The Contractor will provide external oversight of the QARR submission process for all MCOs submitting QARR/HEDIS® data, including MMC plans, HIV-SNPs, HARPs, commercial plans including QHP, and the Essential Plan.

The Contractor will ensure the accuracy of the data submitted through the QARR process and submit a summary report of findings from their annual QARR submission quality check to the State DOH. Each year, the Contractor will provide technical assistance and training to MCOs to support reporting of all measures following existing and new specifications regarding QARR submission/data collection completeness. Examples of this technical assistance may include responding to inquiries on plan interpretation of QARR technical requirement, identifying compliance with HEDIS specification, or providing guidance on submission completeness. This assistance could be plan-specific or collectively for any new plans or new plan types. Types of responses may include emails or phone calls in response to questions from plans about data collection or submission.

The Contractor will assist the State DOH in the preparation of QARR measure specifications for each measurement year to be used by all MCOs. Measures are refined by the State DOH annually to assure reliable and valid measurement. The Contractor will review and validate source code for select State-specific QARR measures, including new measures and enhancements. The Contractor will develop and host an annual technical webinar for MCO staff (QARR participants) on collecting and submitting QARR data which will focus on new or revised QARR/HEDIS® requirements, changes in data submission, validation procedures including any changes, measure calculations, specifications and techniques to optimize QARR/HEDIS® reporting. The Contractor will provide training and technical assistance to all MCOs when new quality and performance measures are incorporated into QARR reporting. The Contractor will collect data from MCOs in the State-defined format(s) and aggregate data across plans and payers into comprehensive sets to be delivered to the State DOH.

The Contractor will monitor that all required files are submitted by the deadline. The Contractor will perform a preliminary data check on QARR submissions to identify any quality issues. This includes comparing data reported via the data submission tool and patient-level detail files, and reconciling discrepancies with the plans prior to submission to the State DOH. Upon completion of this review, the Contractor will document the extent to which the MCO reported the calculated performance measures correctly in the preliminary findings report to the State DOH.

The Contractor will compile and validate the MCO-submitted data files (aggregate quality sets and patient-level detail files) into large data sets to be used by the State DOH annually, coinciding with the QARR annual data submission. As part of the QARR requirements, MCOs are required to contract with an NCQA-certified auditor for an on-site audit of their information systems and data collection (including medical record review processes). The Contractor will review the NCQA-certified auditors' Compliance Audit Final Report designations and findings in the final audit report part of the QARR submission as part of the QARR data validation. The Contractor will review the Compliance Audit Final Audit Report submitted by MCOs each year to further assess the accuracy of performance measures reported by the MCO and determine the extent to which performance measures calculated by the MCO follow specifications and reporting requirements.

The Contractor will also provide ongoing technical assistance to MCOs on a variety of issues connected to quality performance data collection and validation, and serve as a liaison between the MCOs, NCQA subcontractors, and the State DOH. In addition to communicating in writing, the Contractor will participate in meetings with key MCO personnel responsible for the calculation and reporting of performance measures to assist the MCO in implementing recommended corrective actions.

Project 2: Validation of Functional Assessment Data

The functional assessment survey, which includes functional and cognitive assessment data from the Uniform Assessment System for New York (UAS-NY) Community Health and Functional Supplement assessments, are used by the State DOH to establish eligibility for the State DOH's various home and community-based programs, for monitoring of case mix, quality evaluation, and risk-adjusted rate setting. Potential and current enrollees' functional, cognitive and social support systems are evaluated through in-person assessments performed by an Independent Assessor (IA) contracted by the State DOH.

It is anticipated that up to two (2) validations of the functional assessment data will be necessary over the contract period. Validation studies will generally serve to analyze levels of differences between the two assessments but may also focus on a subset of data elements which are the major contributors to those differences. The Contractor will prepare and submit to the State DOH for approval a data validation proposal, including objectives, sampling protocols, validation methodology and analyses, and will work with the IA to implement the validation protocols. The Contractor will refine the proposal based on feedback from the State DOH. Each validation study will include a sample totaling approximately 100 assessments.

The Contractor will perform timely validations of the data and assessment process to ensure its integrity for program functions. Utilizing a side by side audit and validation process, the Contractor will conduct validations on a sample of assessments. Validation assessments will be selected randomly from across the State. Currently, the majority of the program is in New York City, however the Contractor will work with State DOH to develop an appropriate strategy to sample across the state. The Contractor will work with the IA to schedule assessments for potential and current enrollees included in the random sample. Side by side assessments will be done simultaneously and in the same setting as the IA, with the IA maintaining the primary assessor position and the Contractor in an observational, secondary position. The validation should take approximately 12 weeks to perform the paired assessments, four (4) weeks to develop a draft report and submit it to the State DOH, and two (2) weeks to develop a final report and submit it to the State DOH.

4.1.1.3 Review of Compliance with Medicaid and CHIP Managed Care Regulations.

HHS developed standards for MCPs, which are codified at 42 C.F.R. § 438 Subparts D and E, and 42 C.F.R. § 457, as revised by the Medicaid and CHIP managed care final rule issued in 2016. According to CMS's EQR Protocols, at least once every three (3) years, states need to determine the extent to which Medicaid and CHIP MCPs are in compliance with federal standards including availability of services, assurances of adequate capacity and services, coordination and continuity of care, coverage and authorization of services, provider selection, confidentiality, grievance and appeal systems, sub-contractual relationships and delegation, practice guidelines, health information systems, and quality assessment and performance improvement programs.

The State conducts several activities on an annual basis to evaluate Medicaid MCO compliance with federal and State standards for MMC programs. The Contractor will conduct surveys to determine adequate access and availability of care to providers, responsiveness of MCO member services departments, and confirm the accuracy of information in the MCO provider network directory. State standards for these activities are detailed in the MMC/HIV-SNP/HARP Model Contract. Results from these surveys provide information about MCO compliance and inform the on-site surveys conducted by State staff. The Contractor will continue these surveys to annually review MCP compliance with federal standards. The Contractor will work with the State to identify and define standards for compliance; compile results from State DOH audits, surveys of access and availability, member services surveys and provider directory evaluations for each MCO; maintain consistent communication with each MCP; determine if compliance with each federal standard was met for each MCO; analyze findings; and prepare a narrative that outlines compliance determinations.

The Contractor will follow CMS's EQR Protocols for Medicaid and CHIP Managed Care regulations compliance review:

1. Establish compliance thresholds
 - a. Collect Information from the State DOH
 - b. Define levels of compliance
2. Perform the preliminary review (pre-onsite visit)
 - a. Establish early contact with the MCO
 - b. Perform a document review
3. Conduct MCO Onsite Visit
 - a. Determine onsite visit length and dates
 - b. Identify the number and types of reviewers needed
 - c. Develop an onsite visit agenda
 - d. Provide preparation instructions and guidance to the MCO
 - e. MCO interviews
 - f. Conduct exit MCO interviews
4. Compile and analyze findings (post-onsite visit)
 - a. Collect supplemental information
 - b. Compile data and information
 - c. Analyze findings
5. Report Results to the State DOH
 - a. Submit a Report Outline to the State DOH
 - b. Submit a Final Determination Report to the State DOH
 - c. Submit other Reports Requested by the State DOH

The Contractor will use CMS's worksheets in CMS's EQR Protocols (<https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>) for review of compliance with Medicaid and CHIP Managed Care Regulations tools and reporting framework.

Project 1: Validation of Medicaid MCO Provider Directories

The Contractor will conduct a validation of Medicaid MCO web-based provider directories twice a year to ensure that listed primary care providers (PCPs) participate with the MCO and that the staff (at the provider's office) are knowledgeable of the provider's participation. For MMC, HARP, and HIV-SNP plans, this validation is conducted for a random sample of PCPs and obstetricians/gynecologists (OB/GYN) reported in Medicaid MCOs internet-based Medicaid provider directories. Any new MCP types created may also be subject to this survey of PCPs.

The Contractor will place telephone calls to provider offices to obtain verbal confirmation of PCP participation in MCO network, practicing specialty, Medicaid panel status, physical location, and telephone number. The Contractor will report any discrepancies obtained through the survey to the MCO for correction. Providers identified as non-participating during this survey will be disqualified from inclusion in the Access and Availability Survey (see Project 2 below).

The Contractor will perform this validation, describe the methodology, and develop a protocol for administration of the survey for State DOH review/approval. At a minimum, the protocol must describe the threshold for reaching a determination on compliance. The Contractor will generate a random sample of providers stratified by provider specialty using the available web-based provider directories maintained by each MCO and conduct the survey. Sample sizes for each MCO will be based on the number of counties served, the size of the provider network and the number of enrollees. A minimum of 80 providers will be surveyed for plans serving six (6) or more counties. A minimum of 40 providers will be surveyed for plans serving less than six (6) counties. The survey sample frame will approximate an even split between Medicaid and CHIP providers and incorporate a variety of provider types. Across all plans, the completed survey will approximate a minimum of 50, median of 100, and maximum of 150 providers. Survey administration is expected to last approximately six (6) weeks and the Contractor will track completion rates with their survey.

The Contractor will produce a summary report of their survey findings for each MCO, including a determination of compliance with the requirements in the State's Medicaid Model Contract which is available on the State DOH's website at: https://www.health.ny.gov/health_care/managed_care/mamctext.htm. Within two (2) weeks following survey completion, the Contractor will submit the report to the State DOH for review and approval and will provide revisions to the State DOH as needed. Upon approval of these bi-annual reports, the State DOH will distribute the reports to the respective MCOs.

Project 2: Access and Availability Survey

Access and Availability Surveys are designed to evaluate the ability for enrollees to access Medicaid MCO providers and programs in a timely manner, and to determine compliance with contractually defined performance standards (Medicaid Mainstream Model Contract Section 15.2). All MMC plan types and products, including MMC, HIV-SNPs, and HARP require surveying and compliance determination. Any new MCP types or products created may also be subject to these surveys.

Two (2) distinct surveys will be conducted on an annual basis, one focusing on access to primary care/OB/GYN, and the other focusing on access to behavioral health providers/programs.

The Contractor will develop a protocol for conducting these surveys, using a "secret shopper" approach, in which the Contractor will pretend to be an enrollee seeking an appointment with either a medical practitioner or care services program/agency as described below. Practitioners and programs will be identified and sampled for inclusion in the surveys based on the MCO's online provider directory data. The protocol will describe the frequency and periodicity that calls will occur and the threshold for reaching a determination, include scripted scenarios for each survey and a method for tracking phone call completion rates. Calls should be completed within 60 days of survey initiation. The Contractor will obtain review and approval of the protocol from the State DOH.

The Contractor will produce an annual summary report of their survey findings for each MCO, including a determination of compliance with the requirements in the State's Medicaid Model Contract. The Contractor will submit the report to the State DOH for review and approval within two (2) weeks of completion of phone calls and will provide revisions to the State DOH as needed. Upon approval of these annual reports, the State DOH will distribute the reports to the respective MCOs with a finding's determination and request corrections.

Survey 1: Primary Care/OB/GYN Survey

The Contractor will generate a random sample of primary care and OB/GYN providers using each MCP's web-based Provider Directory. Providers identified as non-participating during the Contractor's Medicaid MCO provider directory validation (Project 2) will be removed from the sample frame.

Sample sizes for each MCO will be determined by the State DOH, based on Provider Network Data System (PNDS) data, varying by the size of the provider network and the number of enrollees.

The Contractor will place telephone calls for the following four (4) different scenarios to determine access and availability for specific appointment standards including but not limited to: 1) routine appointments, 2) non-urgent but sick appointments, 3) after-hours calls and 4) prenatal care appointments (OB/GYN providers only). The Contractor will use the template below to track the results of the access and availability survey. The actual number of calls should be adjusted slightly in accordance with the size of the MCO. For example, a smaller plan may have fewer than 300 calls due to the size of enrollment and the number of participating providers, and a larger plan may need additional calls.

The Contractor will complete the survey within three (3) months and will track the success rate of these calls using the template below. If the MCO does not achieve a 75% success rate in satisfying the standards, it receives a Statement of Deficiency (SOD) from the State DOH. MCOs that have received a SOD are required to implement a Plan of Correction (POC), which is submitted to and approved by the State DOH. MCOs are allowed six (6) to eight (8) weeks to implement the POC. The Contractor will include the MCOs who did not meet the threshold in the next round of the access and availability survey.

Tracking Template for Access and Availability Survey

Plan Name:				
Appointment Type	Total Calls Made	Total Appointments	Appointment Rate	75% Threshold
	#	#	%	(Yes/No)
Routine (Includes adult, Pediatrics, OB/GYN)				
Non- Urgent (Includes adult, Pediatrics, OB/GYN)				
After Hours (Includes adult, Pediatrics, OB/GYN)				

Survey 2: Behavioral Health Program Survey

The Contractor will use each MCO's web-based provider directory to generate a random sample of providers of behavioral health services for the following programs: Personalized Recovery Oriented Services (PROS), Mental Health Outpatient Clinics, OASAS Opioid Outpatient, OASAS Outpatient Clinic, OASAS Outpatient Rehabilitation, and OASAS Part 818 Inpatient Rehabilitation and OASAS 820 Residential.

Sample sizes for each MCO will be determined by OMH and OASAS based on PNDS data, varying by the size of the provider network and the number of enrollees.

The Contractor will place telephone calls for each of the following two (2) different scenarios to determine access and availability for specific appointment standards including, but not limited to: 1) routine appointments and 2) non-urgent services. An average of 100 calls will be made to providers in each of the MCOs, requesting appointments or access to services as applicable. The actual number of calls should be adjusted slightly in accordance with the size of the plan. For example, a smaller MCO may have less than 100 calls due to the size of enrollment and the number of behavioral health programs, and a larger plan may need additional calls.

The Contractor will track the success rate of these calls using the template provided in Survey 1 above. If the MCO does not achieve a 75% success rate in satisfying the standards, it receives an SOD from the State DOH and is required to implement a POC. MCOs are allowed six (6) to eight (8) weeks to implement the POC. The Contractor will include the MCOs that did not meet the threshold in the next round of the access and availability survey.

Project 3: Plan Member Services Survey

The purpose of the health plan member services survey is to monitor the accuracy of responses from member services staff given to enrollees or potential enrollees; measure the degree of difficulty in reaching the MCO and monitor the accuracy of the published toll-free member services phone number. This critical information is seen as a major component of patient access to care in the Medicaid program.

MCO Member Services Department surveys are conducted twice a year and consist of telephone calls made to MCO Member Services Departments in approximately 20 MCOs that serve the MMC population, including MMC, HIV-SNPs, and HARP. Any new MCPs, types, or products created may also be subject to these surveys

Member Services Department surveys are conducted using a “secret shopper” methodology, to monitor the accuracy of responses from member services staff to enrollees or potential enrollees, measure the degree of difficulty in reaching the MCO, and monitor the accuracy of the published toll-free member services phone number.

Administration of the survey includes two (2) cycles done each year, with each cycle consisting of two (2) rounds. The first round consists of initial calls by the Contractor; submission of survey outcome reports from the Contractor to the State DOH within approximately two (2) weeks; notification by the State DOH of non-compliant results to the MCOs; and a six (6) to eight (8) week window for non-compliant MCOs to develop and implement a self-directed corrective action plan. The second round of the survey occurs after the corrective period, and consists of follow up calls to the MCOs by the Contractor testing those questions/inquiries that were identified as non-compliant during the initial round of calls; submission of reports from the Contractor to the State DOH within approximately two (2) weeks on the outcome of the second round of calls; and notification by the State DOH of final results to the MCOs.

The first survey cycle is intended to test the general knowledge of the Member Services Department staff, asking for guidance or information from plan staff on how to access care and/or services needed. The survey tool currently consists of 28 questions relative to the following operational areas: family planning, complaints, utilization review, disclosure of information, member care, HIV, dental, orthodontia, personal care services and consumer-directed services. Not all survey questions or areas are relevant to all plans or plan types. As new plan types begin operation, additional questions relevant to those products may be added by the State DOH to the survey tool.

The second survey cycle is designed to assess Member Services Department staff knowledge of the Managed Care initiatives that continue to be integrated into the coverage or specific areas identified as a concern. Topics for the second cycle include, but are not limited to, initiatives developed by the MRT, changes in regulatory guidance and/or areas of concern (identified by advocates, complaints, or fair hearings) that need further evaluation.

Each MCO will be asked up to 26 of the 28 questions in each survey cycle. The Contractor will pose as an enrollee or potential enrollee, calling each MCO on separate occasions for each question, for a total of 26 completed calls to each Member Services Department during each survey administration. Scripts with specified questions are used for each call. Calls must originate from three (3) different area codes in the State (New York City [NYC], and two from Western NY, Central NY, or Capitol Region) so that the call appears to originate from the service area of the plan. Three (3) post office boxes will be maintained by the State DOH (NYC, and two of the Western New York, Central NY, and Capital Region) for use when materials are requested from the Member Services Department as part of the survey.

The Contractor will document the responses obtained during each survey cycle, determine if the MCO is compliant or non-compliant, and submit the MCO report to the State DOH. Once the reports are finalized, the State DOH will notify MCOs in approximately two (2) weeks of the results and then a second round of phone calls will be made by the Contractor to re-test the responses identified as non-compliant. Citations will be issued by the State DOH to Medicaid MCOs that fail a survey cycle with a POC required for the State DOH's review and approval.

Project 4: High-Volume Enrollee to Provider Ratio Survey

On a quarterly basis, PNDS data are used to calculate the ratio of primary care providers (PCPs) to patients for all PCPs serving MMC members. Providers with the highest volume ratios are then surveyed to ensure appointment availability standards are being met.

The Contractor will develop a data collection tool to be reviewed and approved by the State DOH, receive a list of high-volume providers from the State DOH, conduct the annual survey of the 100 open panel PCPs identified as having the highest ratios (based on PNDS quarterly data), calculate appointment availability rates, prepare and submit a findings report to the State DOH, submit draft results notification letters for each MCO to the State DOH, revise the notification letters as per the State DOH's direction, and send the letters and reports to the MCOs. If appointment standards are not being met, MCOs will be required to stop adding patients to the panel of that high-volume PCP. MMC and HIV-SNP plan types will be surveyed. Any new MCP types created may also be subject to this survey.

The survey will be conducted using a "secret shopper" methodology in which the Contractor will pose as a new enrollee seeking care from an identified high-volume ratio provider. The Contractor will place a minimum of three (3) calls within one (1) month to the identified providers to determine if an appointment can be obtained within the acceptable timeframe for a routine visit, a well-child visit and an urgent/non-urgent sick visit (refer to Mainstream Model Contract Section 15.2 as the acceptable timeframes vary by appointment type). The maximum number of PCPs in the survey should not exceed 50 per MCP. The Contractor will report the results to the State DOH. The State DOH will then issue results letters that require the MCOs to develop a corrective action plan to address deficiencies.

4.1.1.4 Validation of Network Adequacy

Project 1: Validation of Provider Network Data

Provider networks must be validated for network adequacy at least once quarterly and as needed between quarters. The Contractor will assess the adequacy of the network offered by each health insurance plan (plan) specific line of business, according to adequacy standards established by the State DOH. Adequacy standards are specific to each line of business.

The Contractor will develop and maintain templates outlining adequacy standards for each line of business. Adequacy standards define the types and counts of providers required by each line of business. For example, every MMC plan must contract with two (2) cardiologists per county in their service area.

Public and commercial health plans are required to submit their provider network information to the State DOH on a quarterly basis, or more frequently when a network change occurs. Data are collected on physicians and other practitioners as well as facilities such as hospitals, clinics, and laboratories. Data collection and standardization are described later in this RFP. Standardized address and servicing county information will be used by the Contractor to determine location of services, which will be used in their network adequacy review.

Using the data submitted by health plans to the State DOH and other existing market data facility lists provided by OMH and OASAS, the Contractor will measure the:

- number of providers in the plan's network in each specialty within a geographic region, as submitted by each health plan for each network.
- number of providers and/or sites in the plan's network in each specialty within a surrounding/nearby geographic region as submitted by each health plan for each network.
- accessibility of providers using time and distance standards (vary by the category of service and type of network under review).
- number of providers available by specialty and geographic region practicing in the State (e.g., all cardiologists practicing in Albany county as determined by licensure or credentialing data for each health plan network).
- number of providers available by specialty and geographic region participating with all health plans submitting PNDS data to the State DOH (e.g., all cardiologists practicing in Albany county as submitted by all plans).

- number of providers available by specialty and geographic region participating with all health plans submitting PND data, by line of business (e.g., all cardiologists practicing in Albany county as submitted by Medicaid plans).

The Contractor will use these measurements to determine whether or not each standard has been met by each MCO network, within each geographic region. Based on the findings of the above validation, the Contractor will categorize unmet standards into deficiency types by plan and by product. Deficiency types help relevant subject matter experts, State and network adequacy coordinators at health plans, to understand if a standard was not met because there are insufficient provider type(s) in the geographic region, or if a standard was not met because the plan failed to contract with available providers. The Contractor must maintain historical adequacy reviews, and trend data over time. All-plan adequacy review results will be combined by the Contractor into a data set that will be shared with the State DOH on a quarterly basis after data are received from the plans.

The Contractor will create and maintain metadata that describe how their analyses are performed. The Contractor will provide technical assistance to the MCOs, as needed.

4.1.1.5 Validation of Encounter Data Reported by the Medicaid and CHIP MCP

As per CMS protocols and 42 C.F.R. § 438, MMC plans are contractually obligated to submit data to the State DOH on enrollee encounters with Medicaid providers. Encounter data are the information related to the receipt of any item or service by an enrollee in an MCP and reflect that a provider rendered a specific service under a managed care delivery system, regardless of if or how the MCP ultimately reimbursed the provider. The availability of timely, accurate, and complete encounter data is critical to effective operation and oversight of MCOs.

Encounter data in the Managed Care Encounter Data System (MEDS) are used by the State DOH for a number of purposes and activities including tracking utilization patterns, developing risk adjusted capitation payments, quality performance incentive calculations, quality performance measure calculations, clinical severity calculations (using 3M's Clinical Risk Group [CRG] methodology), fraud and abuse monitoring and other evaluation and research activities. Periodic and timely validation of the Medicaid encounter data is essential to address problems in reporting and data completeness as well as to assess new health plans' readiness to submit data.

The State DOH requires monthly submissions of encounter data for all enrollees in MMC, including MMC/CHIP, HIV-SNP, HARP, EPs and MLTC plans. As new types of plans and products are brought into MMC, monthly encounter data submissions will also be contractually required. These data are collected and initially processed by the State's Medicaid fiscal agent. Edited reports are created on a monthly basis and the State DOH is provided with a monthly file of encounter records that have passed all initial edits. Several different approaches to validating encounter data submissions have been used by the State DOH including medical record reviews of up to 500 records, review of targeted plan problem areas and surveys to determine new plan readiness to submit or to determine root causes of reporting problems for existing plans based on compliance and completeness reports.

The Contractor will design an annual encounter data validation strategy, including a sampling strategy to evaluate the completeness and accuracy of MCO encounter data submissions, including the infrastructure essential for accurate and complete encounter reporting (individual product lines, problematic areas and/or follow up indicated by validation documentation submitted by the MCOs). The Contractor will be responsible for: preparing a validation analysis plan for State DOH approval including a mechanism to obtain information regarding internal and external factors in the data submission process and the role of external vendors or contractors; evaluating the validity and completeness of the data; assessing new MCOs' readiness to submit encounter data including developing and hosting a webinar to train new MCOs; analyzing and providing technical assistance to MCOs regarding their use of vendors in data collection; continued evaluation of provider-sponsored information system capability; and assisting MCOs in data and process quality improvement. Since encounter data are submitted for enrollees in all MCOs and product types, the schedule for validating encounter data by product line and plan type may be rotated. The Contractor will recommend the selection of MCOs and/or data items for validation based on their analysis of data completeness and compliance reports. The Contractor will prepare a draft validation report for State DOH review and feedback and a final validation report. Upon State DOH approval, the Contractor will submit the final validation report with a cover letter to the MCOs.

The Contractor will follow CMS's EQR Protocols for validating the accuracy and completeness of encounter data submitted by MCOs:

1. Review State requirements
2. Review the MCO's capability
 - a. Review the MCO's Information System Capability Assessment (ISCA)
 - b. Interview MCO personnel
3. Analyze electronic encounter data
 - a. Develop a data quality test plan based on data element validity requirements
 - b. Encounter data macro-analysis – verification of data integrity
 - c. Encounter data micro-analysis – generate and review analytic reports
 - d. Compare findings to State DOH-identified benchmarks
4. Review medical records
5. Submit findings

The Contractor will use CMS's worksheets in CMS's EQR Protocols for encounter data validation tools and reporting framework. Information can be found at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>.

4.1.1.6 Administration or Validation of Quality of Care Surveys

According to CMS's EQR Protocols, states may use information from surveys to help create a person-centered health care environment for those enrolled in Medicaid and CHIP. Enrollee surveys are used to assess their experience with their health plan and its providers, and with the quality of care they receive. Since 2000, the State DOH has measured the perceptions of MMC enrollees regarding access, quality, and overall satisfaction with their health care and health plan, through standardized consumer surveys. Surveys include those made available by the Agency for Healthcare Research and Quality (AHRQ) through their Consumer Assessment of Health Plans and Systems (CAHPS®) program, and "home-grown" (non-CAHPS®) experience of care surveys. The Contractor is required to either attain status as a NCQA-certified CAHPS® vendor or subcontract with an NCQA-certified CAHPS® vendor to conduct the CAHPS® surveys.

The Contractor will design and conduct valid and reliable surveys for enrollees and providers. The Contractor will administer enrollee experience of care surveys made available by the AHRQ through the CAHPS® program. With the assistance of the State DOH, the Contractor will also develop additional non-CAHPS® enrollee experience of care surveys and provider access and availability surveys. The Contractor will design the methodology, protocol, sampling, data collection and analysis, administration method, and tools for these additional surveys.

The Contractor will follow CMS's EQR Protocols for administration of consumer and provider quality of care surveys:

1. Identify the survey purpose, objectives, and audience
2. Develop a work plan
3. Select the survey instrument
4. Develop the sampling plan:
 - a. Define the study population
 - b. Determine the type of sampling to be used
 - c. Determine the number of units to sample
 - d. Select the sample
5. Develop a strategy to maximize the response:
 - a. Maximize completeness of sample information before survey launch
 - b. Design a data collection strategy that maximizes response
 - c. Specify the method used to calculate the response rate
 - d. Include a plan for a non-response analysis
6. Develop a quality assurance plan
7. Implement the survey according to the work plan
8. Prepare and analyze survey data and present the results in a final report:
 - a. Implement post-processing procedures
 - b. Calculate the sampling weights
 - c. Conduct a non-response analysis

- d. Analyze survey data
- e. Prepare and submit a final report

The Contractor will use CMS's worksheets in CMS's EQR Protocols for the administration of quality of care survey tools and reporting framework. Information on the CMS Protocols can be found at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf> and the CMS worksheets are located at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-worksheets-2019.zip>.

Project 1: CAHPS®

The Contractor will develop a work plan for the State DOH's approval, including the CAHPS® survey design/methodology/protocol, timeline, sampling strategy, data analysis plan, administration method, survey tool including State specific questions and specific areas for analysis. The Contractor will conduct the CAHPS® surveys annually using a random sample of enrollees selected from the Medicaid enrollment and eligibility database and will validate the sample. Surveys will consist of up to three (3) mailings, with telephone follow-up when necessary to increase the response rate. The Contractor may also be asked to remove the phone component if survey method trends indicate it will not be helpful. The Contractor may be asked to include a URL to a web-based survey in one (1) of the mailings. The Contractor will prepare the survey in a scannable format and will prepare a final report analyzing survey findings. The sample size may be up to 2,000, to allow for an oversample, from each different MMC product (e.g., Mainstream MMC [including CHIP], HIV-SNP, and HARP) in order to reach an anticipated response rate of 25-30%. To calculate volume of the sample, the Contractor will take the number of MMC products at any given time and multiply times the highest possible sample size. Any new MCP types created will also be subject to the survey.

Translation of the survey tools into at least one (1) other language may be required. Surveys will be required annually, alternating between child and adult surveys each year. The Contractor will provide the State DOH with a final report for approval, provide the State DOH with the data generated from the responses for future analyses, and prepare and submit the CAHPS® survey tools and data to AHRQ. The Contractor, in conjunction with the state DOH and the MCOs, may also be asked to develop and monitor quality improvement strategies related to CAHPS results.

Project 2: Experience of Care Surveys (Non-CAHPS®)

As more clinically complex, potentially vulnerable populations are brought into MMC, the State DOH will seek to learn more about members' transition into managed care, as well as the experience these members have in the managed care environment. The Contractor will develop a work plan for State DOH approval, including the survey design/methodology/protocol, timeline, sampling strategy, data analysis plan, administration method and survey tool in a scannable format for mailing. The Contractor will prepare an introductory letter to the MCOs and conduct up to 10 customized scannable satisfaction/experience of care surveys for special populations including enrollees in Mainstream MMC, MLTC, and HARP. Any new MCP types created may also be subject to survey.

The Contractor will work with the State DOH to issue two (2) surveys per year consisting of at least two (2) mailings, according to the population and survey purpose. Each survey will involve a minimum sample of 500 for each of the MCOs or subgroup included in the study, with an anticipated response rate of 25-30%. Currently the number of plans is 13 MMC, 3 HIV-SNP, 13 HARP, and 45 MLTC. These numbers are subject to change over the course of the contract period. The largest anticipated sample will be for MLTC satisfaction, with a total sample size of 22,500 (45 plans X 500 per plan). Translation of the survey tools into at least one (1) other language may be required. The Contractor will prepare a final report for State DOH approval that analyzes the survey findings, provide a member-level data set of responses to the State DOH, and participate with the State DOH in an annual conference call or on-site meeting with MCOs to discuss the survey findings and improvement strategies. The Contractor, in conjunction with the State DOH and the MCOs, may also be asked to develop and monitor quality improvement strategies related to experience of care survey results.

4.1.1.7 Calculation of Additional Performance Measures

As per 42 C.F.R. § 438.358(c)(3), states may have the EQRO calculate performance measures in addition to those specified by the state for inclusion in MCO QAPI programs. Performance measurements are used to evaluate the degree to which evidence-based treatment guidelines are followed, strengthen accountability, support improvement initiatives, and demonstrate a variety of activities and health care outcomes for particular populations.

The State DOH implements a standardized approach for the development and maintenance of the State specific quality measures used in various programs, including the Medicaid Value Based Payment (VBP) initiative. The Contractor will create these measures. State specific measures are used across all product lines including Medicaid and Commercial and have long served to fit a programmatic gap where no appropriate quality measure existed.

The Contractor will identify priority areas or gaps where quality measures are needed. The Contractor will determine need based on analysis of existing quality measurement data, review of the peer-reviewed and grey literature, clinical practice guidelines, stakeholder input from existing State DOH meeting groups (e.g., Clinical Advisory Group, Measure Support Task Force, Statewide Steering Committee), other subject matter experts (e.g., research personnel at OMH), and in consultation with the State DOH. Based on the Contractor's findings, the Contractor will refine and finalize new measure topics. Candidate measures will be documented using high-level statements that include a tentative description of the proposed denominator and numerator for the measures. The Contractor will also complete a measure information form provided by the State DOH.

The Contractor will then review existing measures for comparison to candidate measures. This review will include: 1) an assessment of the ability to use existing measures without change (adoption), 2) the potential for adaptation of existing measures, and 3) the potential for any existing measures to serve as a model for new measure development. The Contractor will also review existing studies that can be used as the evidence base for new measures. Once complete, the Contractor will provide the State DOH with a summary report of the key findings of all components of these reviews, detailing opportunities for measure coordination. The Contractor will also compile scientific evidence using the National Quality Forum evidence criterion (e.g., http://www.qualityforum.org/Measuring_Performance/Submitting_Standards/NQF_Evidence_Attachment-2147403211.aspx) and complete a measure justification form.

Prior to the development of detailed technical specifications, the Contractor will convene a panel comprised of representatives from the State DOH and other State agencies (e.g., OMH, OASAS, OPWDD), including quality measurement and subject matter experts, to review the Contractor's measure concept, proposed measure, evaluation of existing measures, and scientific evidence. The Contractor will assist with meeting logistics and develop relevant materials for review. Upon meeting completion, the Contractor will provide a report summarizing the key findings of the panel.

Should the State panel recommend formal development and implementation of a concept measure, the Contractor will develop the technical specifications for data collection and calculation of the measure. The technical specifications are to explicitly define data sources and coding sets needed for the measure specification development. For risk adjusted measures, the Contractor will also complete a Risk Adjustment Methodology Report.

The Contractor will then construct a comprehensive data protocol and develop source code for any administrative measures. The Contractor will also develop a flowchart documenting key decision points in the technical specifications, reports summarizing measure specifications, source code, and baseline data with quality measure results, according to the State DOH's specifications.

The Contractor will then develop a workplan for State DOH approval for testing the measures including data sources and specific areas for analysis. The Contractor will implement the workplan, analyze test results, and refine measure specifications as needed. The Contractor will report their results to the State DOH in a summary report.

Upon completion of measure testing, the Contractor will prepare documentation to solicit public comment on the measures. The Contractor will be responsible for responding to public comments and reporting this communication to the State DOH in a summary report. The Contractor will facilitate any revisions from the State DOH to refine the measures.

Following the first year of new measure administration, the Contractor will provide the State DOH with analysis plans, report formats (including data tables/charts/displays), and draft reports for approval. The Contractor will analyze and present the results to the State DOH and its stakeholders (Clinical Advisory Group, measure support groups, VBP workgroup) in three (3) to five (5) meetings.

Finally, the Contractor will review measure performance on an ongoing basis, evaluating the usefulness and ultimately providing recommendations to the State DOH for continuation, refinement, or retirement of measures. Measures should be considered for retirement when: 1) the overall performance is very high across all organizations being measured, 2) the information produced is no longer valuable, or 3) a new measure supersedes an existing one. This continuing evaluation/maintenance of measures will be documented in a formal report submitted annually from the Contractor to the State DOH for approval.

The Contractor will follow CMS's EQR Protocols for the calculation of additional (non-QAPI) performance measures to monitor the care provided by MCPs to enrollees covered by Medicaid and CHIP:

1. Prepare for measurement:
 - a. Identify the performance measures to be calculated
 - b. Prepare for data collection
 - c. Identify required data elements data sources, and data quality issues
2. Calculate measures:
 - a. Collect performance measure data
 - b. Clean data
 - c. Integrate data into performance measure repository
 - d. Conduct preliminary analysis
 - e. Calculate the denominators, numerators, and rates
3. Report results:
 - a. Report preliminary performance measure results
 - b. Analyze performance measure results
 - c. Submit a final report to the State DOH

The Contractor will use CMS's worksheets in CMS's EQR Protocols for additional (non-QAPI) performance measures calculation tools and reporting framework. Information on the CMS Protocols can be found at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf> and the CMS worksheets are located at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-worksheets-2019.zip>.

4.1.1.8 Conduct Focused Studies of Health Care Quality

According to CMS's EQR Protocols, states may direct their EQROs to conduct focus studies for quality improvement, administrative, legislative, or other purposes. A focus study is a study used to identify a particular aspect of clinical care or nonclinical services provided by an MCO at a point in time which is known or suspected to need improvement. The goal of conducting clinical and focused studies is to identify opportunities that may be used to improve the quality of care delivered to members enrolled in all types of MCOs. This process will enable the State DOH to obtain valid information, make an assessment regarding the quality of care, and collectively develop an effective process to improve MCO performance in a defined area.

All clinical studies must be conducted in accordance with generally accepted principles of research design and statistical analysis in order to produce valid and reliable information. Clinical studies must have clearly defined goals and/or standards for the provision of services and be conducted with a clear understanding of standards of care, as these will provide a baseline for future assessment to determine whether the interventions implemented improve the provision of care. The studies will be identified based upon the epidemiology of the enrolled population and, whenever possible, will utilize practice guidelines or standards which represent the consensus of the medical community and/or evidence-based practice. Focused studies may involve retrospective medical record reviews, data collection activities, review of administrative data systems, and analysis.

The Contractor will work with the State DOH to identify the topic and scope of the focus study. The Contractor will develop sound methodology in their study design, implementation, data collection, analysis, and reporting. The Contractor will review the focus study design and implementation using documents provided by the MCO. The Contractor then will report to the State DOH on its findings from the focused study in the EQR Technical Report.

The Contractor will collaborate with the State DOH to design and conduct up to five (5) focused clinical studies for Medicaid/CHIP and HIV-SNP plans, up to two (2) focused clinical studies for MLTC, and up to three (3) behavioral health focused clinical studies for HARP plans. Focused study topics will be chosen by the State DOH with input from partner State agencies, the MCOs and the Contractor. Priority topics will be clinical conditions, public health areas, or health service delivery issues which have the highest prevalence or incidence, and which have the greatest potential for improving health outcomes. The focused studies will center on specific clinical areas of interest which involve primary and preventive care, chronic care, acute care, behavioral health care and HCBS. Focused studies may also evaluate health service delivery issues such as coordination, continuity, access to and availability of needed services. Examples of previous focused clinical study reports are available on the State DOH's website at: http://www.health.ny.gov/health_care/managed_care/reports/index.htm.

The Contractor will develop a study design for State DOH approval that defines: the specific aim of the study, stated goal(s), measurement indicators, methodology (including definition of study population and sampling techniques), type of data to be collected and the electronic tools to be utilized for data collection with instructions, data collection guidelines, data analysis plan (including statistical tests to be performed on the data and table/chart displays), and intended use of the data. The Contractor will train reviewers on the data collection tools, submit requests to MCOs to provide data or medical records and collect the data and input the data into the data collection tool.

Studies involving populations in Medicaid/CHIP and HIV-SNP plans that necessitate medical record reviews will require the review of up to 600 records per study. HARP studies necessitating medical record reviews will require the review of up to 400 records per study. Studies involving HCBS, including members enrolled in MLTC and FIDA-IDD plans will require the review of up to 200 records per study. It is important to note that not all focused studies will involve the review of medical records.

The Contractor must assign staff that are clinically competent and skilled in the process of reviewing and evaluating health care services provided to the Medicaid population, specific to the type of study. For studies involving medical record reviews, professional nurse reviewers should be utilized in the initial medical record review with a second level review by physicians (or psychologists) to provide an over-read for specific cases that are more complex than average or do not meet defined standards. The Contractor must also have an appropriate process and the professional staff to develop standards or criteria for review and develop corresponding review tools.

The Contractor will present their findings from the clinical focus studies in a technical report. The Contractor will prepare a data analysis plan outlining the report format, including table formats, for State DOH approval, and the Contractor will analyze the data. The final report will include but is not limited to an executive summary, introduction, a narrative summary of the report findings, study questions/objectives, methodology (including sampling method), findings, conclusions (including discussions), and recommendations. The report narrative and tables are to be presented in a clear and accurate format. The Contractor will present the findings in a meeting to MCO medical and quality directors. The Contractor will then send the final report to the MCOs. The Contractor, in conjunction with the State DOH and the MCOs, may also be asked to develop and monitor quality improvement strategies related to focused clinical study results.

The Contractor will follow CMS's EQR Protocols for conducting focus studies on health care quality:

1. Select the study topic(s)
2. Define the study question(s)
3. Select the study variable(s)
4. Develop a plan to study the population
5. Collect data
6. Analyze and interpret study results
7. Report the results to the State DOH

The Contractor will use CMS's worksheets in CMS's EQR Protocols for conducting health care quality focus studies tools and reporting framework. Information on the CMS Protocols can be found at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf> and the CMS worksheets are located at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-worksheets-2019.zip>.

4.1.1.9 EQR Technical Report

In accordance with 42 CFR 438.364, states are required to have an EQRO produce a detailed annual EQR Technical Report that summarizes EQR findings on access and quality of care in the State's MMC program. The Contractor will produce this report in a manner and template approved by the State DOH. To fulfill the EQR requirements, these reports must at minimum contain the following information:

- A description of the way the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO.
- Each EQR-related activity conducted for the report must describe the objectives; technical methods of data collection and analysis; a description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii); and conclusions drawn from the data.
- An assessment of each MCO's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of health care services furnished by each MCO including how the State DOH can target goals and objectives in the Quality Strategy, under §438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
- Methodologically appropriate, comparative information about all MCOs, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- An assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the Contractor during the previous year's EQR.

The report will address EQR activities for all Medicaid MCOs including MMC/CHIP, HIV-SNP, MLTC, and HARPs, and any new types of plans brought into the managed care program.

The report will be comprised of individual MCO reports and a statewide summary which should include State-level recommendations for performance improvement. Individual MCO reports are to be included as appendices and in addition to the information outlined above, must include the projects referenced earlier in this RFP related to the EQR Technical Report including:

- Results of PIP validations
- Results of validation of measurement of quality performance and access to care
- Results from review of MCO compliance with Medicaid standards
- Results of the Network Adequacy evaluation
- Results from validation studies of plan encounter data, as available
- Results from consumer satisfaction surveys
- Results from Clinical and Non-Clinical Studies

Data files will be provided electronically to the Contractor from the State DOH. The Contractor will calculate trends, ratios or other descriptive indicators. The Contractor will include findings from MCO compliance with State standards for access to care, structure and operations, and quality measurement and improvement as well as any additional data and information requested by the State DOH, including information about MCO finances, corporate profiles, enrollment, and service utilization rates. The reports will also include statewide benchmarks and trends over time. The information contained in each report must not disclose the identity or other protected health information of any patient.

The statewide summary report must also include a section that addresses the effectiveness of the State's Quality Strategy for the MMC Program and determine whether any updates to the Quality Strategy are necessary based on the results of EQR. The most recent Quality Strategy is available at:

https://www.health.ny.gov/health_care/managed_care/quality_strategy.htm.

In response to the report, MCOs are required to respond, including a POC, to address each of the identified weaknesses. This response to the previous year's recommendations should be included in the individual MCO report.

The Contractor will submit an outline of the proposed report format, including indication of data sets to be included, to the State DOH no later than 90 days prior to the end of each calendar year. The Contractor will submit a draft of the summary report and individual MCO reports to the State DOH no later than 30 days following the end of the calendar year. The State DOH will finalize and make available an updated report by April 30 of each year. As such, the Contractor must submit the draft report to the State DOH for approval and complete any necessary revisions as per feedback from the State DOH. The Contractor must submit the final report to the State DOH and MCOs no later than 90 days following the end of each calendar year.

4.1.1.10 Focus Groups

The Contractor will be required to conduct focus groups. Focus groups will generally be with Medicaid recipients however certain groups may involve providers or others as directed by the State DOH. The focus group size and duration will vary on the population depending on the research objectives and areas of inquiry. Typically, a group will involve six (6) to eight (8) people who meet once for a period of around one and a half (1.5) hours to two (2) hours. The Contractor's interviewer will use a focus group guide to ask participants questions or to prompt them if there is a lack of response or clarity. The Contractor will develop recruitment criteria which will need to be defined by the research objective, ability to recruit, and other known constraints of the population. Groups generally work best when they are more homogeneous but there are topic areas where group heterogeneity may be appropriate. The Contractor should be clearly in charge of the management of the group, transportation/childcare needs if necessary, refreshments, incentives, or other unanticipated problems. The Contractor should plan to have present one (1) facilitator and one (1) note-taker. There should also be a system for the Contractor to record the interview with multiple audio recorders. Actual questions should not be provided to the focus group beforehand, though a list of general topics is appropriate.

The actual time in the focus group generally involves five (5) phases:

1. Scene setting and ground rules
2. Individual introductions
3. The opening topic
4. Discussion
5. Ending the discussion

An online version of the focus group may use an online meeting tool (e.g., Skype, Zoom) to facilitate video and chat during the focus group if a physical meeting is not possible.

From either type of focus group, physical or online, the Contractor will produce transcripts of the entire event from the audio recording. Concurrent notetaking by the Contractor will help to facilitate this and check the record of the audio recording.

Analysis of the transcript by the Contractor may involve either deductive or inductive coding depending on the type of research inquiry. Deductive coding should use codes that were developed prior to data collection. Inductive coding should use the text itself to develop codes from the data. The process of coding itself by the Contractor should follow a process that includes line by line coding of the full text, categorization, and theme determination. This process should produce a report by the Contractor which includes the major themes as well as textual evidence (e.g., quotes) to support these themes and may suggest areas for follow-up or improvement work. The report may include some quantitative counts of data that are appropriately linked to the research question.

4.1.2 Office Based Surgery

In accordance with State Public Health Law (PHL) §230 d and 2998 e, the Office Based Surgery (OBS) program assures patient safety and quality of care for procedures performed in the accredited OBS setting through the monitoring of accreditation and the measuring and quantifying of data received through adverse event reporting. The State DOH has identified the following three (3) accrediting organizations that private practices seeking to perform OBS must use to become accredited: The Joint Commission, the Accreditation Association for Ambulatory Health Care and the American Association for the Accreditation of Ambulatory Surgical Facilities. The State DOH has a collaborative agreement with each agency that is updated at least every three (3) years and more often if needed. Elements of the agreement include receiving a monthly file of OBS accredited practices and those practices with an accreditation status change. Through Quality of Care reviews of reported adverse events, the OBS program makes recommendations to improve quality of care for OBS related to identification of potential risks and/or trends in standards of care.

The law defines OBS as invasive or surgical procedures involving more than minimal sedation or local anesthesia (moderate sedation, deep sedation and general anesthesia) performed by licensees in non-Article 28 offices. Licensees identified in the law are physicians, physician assistants and specialist assistants. The law also requires that all physician practices performing OBS as defined above to become accredited by a State DOH designated agency and to report specific adverse events to the State DOH OQPS. Licensees performing OBS in an unaccredited office practice and failure to file adverse event reports falls within the definition of professional misconduct identified in Section 6530(48) of the State Education Law.

PHL § 230-d (1) (b) identifies reportable OBS adverse events as patient death within 30 days, unplanned transfer to a hospital or emergency room visit within 72 hours of OBS for reasons related to the OBS, unscheduled hospital admission or assignment to observation services within 72 hours of the OBS for longer than 24 hours, any other life-threatening event or suspected health care transmission of a blood borne pathogen. These adverse events are to be reported within three (3) business days of the occurrence of the adverse event to OQPS. Adverse events are reported to the State DOH electronically or via certified mail using a standardized Adverse Event Report (AER) form.

As part of monitoring accreditation and the measuring and quantifying of data received through adverse event reporting and quality of care review responsibilities described above, the Contractor will assist in identifying potential risks and/or trends in standards of care that indicate areas needing improvement in the quality of care provided in the OBS setting. These activities will be provided through maintenance and support of the OBS program's web based electronic AER submission form and password protected OBS Dashboard/AER Database application, and the performance of Quality of Care reviews for received AERs. The total number of accredited practice sites in the State has remained stable since mid-2014 with an average of 965 accredited OBS practices. OBS practices are both single and multi-specialty with some overlap in the types of procedures performed in ambulatory surgery centers. Approximately 630 AERs are received per year. Approximately 15-20% of AERs involve multiple reports (e.g., one [1] from the proceduralist and one [1] from the anesthesiologist for the same surgery). Upon receipt, all AERs are given a unique case ID and processed by the OBS program; an initial review to determine and prioritize the need for requesting medical records (i.e., OBS practice, hospital, medical examiner), immediate referral to the accrediting organization or the State DOH's Office of Professional Medical Conduct (OPMC), and/or need for a comprehensive quality of care review by the Contractor. AER processing, initial review, and quality of care reviews are completed using the electronic OBS Dashboard/AER Database; paper submissions require entry of the AERs' information into the electronic database by the OBS program staff. The Contractor will be assigned cases and conduct quality of care reviews using the OBS Dashboard/AER Database.

Quality of care reviews are assigned to the Contractor once all requested data and/or medical records are received. The purpose of the Quality of Care review process is to determine if the adverse events were potentially related to the office based procedure performed, identify cases where adverse events were potentially preventable, identify factors contributing to the adverse events, and identify trends in reported adverse events. Reviews are to be conducted by a Registered Nurse (RN) and in order of priority and time of receipt. The RN is to use the OBS program's electronic applications, procedures, and forms to review the AER(s), the associated medical records (OBS practice, hospital, autopsy/medical examiner and Emergency Medical Services [EMS]), documentation of Quality of Care review findings with summarization, recommendations for referrals and quality of care determination. Review of multiple records per case results in approximately 900 records among the approximate 630 cases anticipated for the Contractor's review per year. An average of 52 cases per month are assigned to the Contractor for a comprehensive quality of care review. OBS practice records and hospital records are requested for approximately 85% of cases. In an uncomplicated, Non-Mortality case, the total time for the Contractor to complete a Quality of Care review is approximately four (4) hours. In quality care reviews of Mortality cases, the review of associated medical records, documentation, case determination and recommendations for follow up may take up to a total of five (5) hours.

The Contractor will train any of its staff to understand the State DOH's review system, including the State DOH's goals and objectives for conducting a quality of care AER review; Public Health Law, regulations, and State DOH policies and procedures regarding OBS; how to conduct medical record reviews and abstract information necessary to make a case determination from the medical record regarding the quality of care provided; how to incorporate guidelines and standard practices into review activities; and how to perform internal quality control monitoring and training to ensure accuracy and consistency in conducting a quality of care AER review.

A Quality of Care review conducted by the Contractor which reveals questions or concerns about the care delivered may also require consult to and review by a physician specialist. The Contractor will identify and provide an appropriate specialist for review of the case in question. The most common physician specialists consulted for reviews have been anesthesiology, plastic surgery, vascular surgery, and gastroenterology. The Contractor will notify the OBS program of the identified need for a specialist consult and obtain approval from the OBS program for the specialist consultation, prepare and initiate the approved consult request, receive the consultant's documentation and update the Quality of Care review documentation to include the consultant's summary and findings. The total length of time associated with the consult and review of a case by a specialist physician takes approximately two (2) hours. The OBS program may also reassign a closed case to the Contractor for a physician specialist consult, which will include the Contractor selecting and contacting the physician specialist to complete the consult, preparing the consult request (form with identified concerns for specialist review), receiving and updating documentation of the specialist's summary/findings using the OBS program's electronic application, and returning the completed findings/recommendations and/or indication for referral(s) to the OBS program.

The Contractor will participate in monthly meetings and provide the State DOH with a monthly progress report including the total number of cases that are 1) carried over from the previous year, 2) received and completed for the previous month, 3) open, 4) awaiting medical records, 5) ready for RN review, 6) ready/undergoing physician review, 7) reviewed by the physician, and the average number of cases received and completed per month. For #3-7 above, data will be provided in a format depicting the year the AER was submitted to the State DOH. The Contractor will also participate in up to four (4) quality improvement meetings to review findings and report on core service activities. The OBS program will provide the Contractor with a list of cases that will continue from the previous year.

The Contractor, through the existing AER and OBS Dashboard/Quality of Care Review applications, will be responsible for data collection, database edits, updates, maintenance, and monthly SAS export to support the OBS program's quality of care reviews and quality improvement initiatives. All current and future data collection and reporting systems of the applications must be structured to be consistent with and support the above functions and comply with the State's Office of Information Technology Services (ITS) policies regarding security and privacy.

The Contractor will maintain two (2) existing applications for the OBS program: 1) a TLS 1.2 or higher compliant web-based electronic AER submission form and 2) a password protected OBS Dashboard/AER Database application for authenticated and authorized users. The portal and database must remain in compliance with NYS ITS Security Policies.

These applications will be hosted by the Contractor. The applications are currently in the Amazon Web Service (AWS) GovCloud, an isolated AWS region designed to allow U.S. government agencies and customers to move sensitive workloads into the cloud by addressing their specific regulatory and compliance requirements. The AWS GovCloud (US) Region restricts physical and logical administrative access to U.S. persons only and provides FIPS 140-2 endpoints.

The Contractor will maintain a Business Associated Agreement (BAA) with Amazon and operates under a Data Exchange Agreement executed with the NYS DOH and NYS Office Information Technology Services.

The electronic AER submission form will be used for the following:

- i. Mandated reporters, licensed physicians, physician assistants (PAs), or Specialist Assistants (SAs), in the State are able to submit AERs through a public-facing website utilizing TLS 1.2 or higher to ensure NYS ITS Security policies for data in transit are met.
- ii. The reporter can be identified using the license number submitted on the AER.
- iii. The reporter is able to upload the patient's medical record when submitting the AER along with any other related documentation.

The password protected OBS Dashboard/AER Database application for authenticated and authorized users will allow the application users to:

- i. Create unique AER IDs for each AER submitted through the AER web interface and received into the OBS Dashboard/AER Database.
- ii. Record whether an AER was submitted electronically through the electronic AER web application or whether mandated reporters have submitted the AER form to the State DOH on paper, requiring the OBS program to enter the written information into the electronic AER web application.
- iii. Review AERs submitted through the AER web interface.
- iv. Assign submitted AERs to both the OBS program and contracted users.
- v. Provide the OBS program and contracted quality of care reviewers with the ability to view the full AER, conduct and enter quality of care reviews and review findings, request medical records, consults, referrals, and upload medical records and other documentation.
- vi. To access the database and dashboard via predefined security roles that tailor the data and rights of the user to their corresponding business role.

The Contractor will conduct a full assessment of the business, software, and hardware and infrastructure environments of the electronic AER form and OBS Dashboard/AER Database application within the first three (3) months of contract award and develop a transition plan for subsuming the implementation and support activities from the existing Contractor. The State DOH will provide the Contractor with the Software Design Description Document, including the business perspective of the requirements for support of the electronic AER and OBS Dashboard/AER Database and provide support of the transition plan for subsuming implementation and support activities from the existing Contractor. The existing dashboard application provides the OBS program user with the ability to import files containing accredited OBS practice site roster information and generate periodic reports using the roster data. Reports screens for frequent queries will be available to OBS program users and results from these screens will provide the user with the ability to export their results.

The Contractor will conduct maintenance and support activities on a regular scheduled basis for the OBS Dashboard/AER applications:

- i. The applications will be backed up nightly at 1:00 AM EST and follow a retention scheme of 30 days of nightly backups, and 11 months of monthly backups. Monthly backups will be retained for one (1) year. Data can be restored from these backups to a new instance independent from the original for data rescue and/or reinstatement.
- ii. Provide a process for the monthly transfer of roster files containing OBS practice accreditation information from the State DOH to the Contractor by email.
- iii. Provide a process for quarterly data transfer from the Contractor to the State DOH.
- iv. Provide storage of the database applications.

- v. Provide Google analytics for the AER/Dashboard applications, which is a monthly summary of the number of distinct users, bounce rate, average session duration (includes sessions that bounced), day of the week most users accessed the site, type of device users used to access the application (desktop or mobile), and average page load time.
- vi. IT Support and assistance will be provided for OBS practices submitting AERs through the Adverse Event Form Web-based application and for OBS program and Contractor staff using the OBS Dashboard/AER Database application.
- vii. Develop and maintain a help desk ticket answering system housed on the OBS AER web page and OBS Dashboard Application.
 - 1. Provide a toll-free help line, manned between the hours of 9:00 am to 5:00pm EST.
 - 2. Response and/or turnaround time for help desk tickets will be 24 hours.

Changes to the existing applications will need to occur that will require special processing. These changes may include interface revisions and updates, enhancements and modifications required to meet additional State or federal requirements. Within 90 days of contract execution, the Contractor will provide for State DOH review and approval a change management plan to act as a guide for how the Contractor and State DOH will submit, review and enact changes. Individual change requests will be provided on a fixed “not-to-exceed” cost based on the hourly rates multiplied by the number of hours provided in the Cost Proposal. Any reproduction of information will require the Contractor to obtain permission prior to reproduction from the State DOH.

The Contractor will request State DOH approval for transportation or storage of information outside of an approved storage facility as well as transmission outside the State Entity.

4.1.3 Provider Network and Panel Data Systems

Health plans must report provider network and panel data to the State DOH on a quarterly basis, or more frequently when network changes occur. The Contractor will maintain a data intake website for analysis, communication, tracking, and reporting system to be used by health plans and the State.

PNDS Overview

Since 1996, the State DOH has collected provider network data from managed care health plans through the Provider Network Data System (PNDS). From 2016 to 2019, PNDS expanded to collect data from commercial managed care and non-MCPs offered on and off the NYSOH Exchange, as well as publicly funded plans including Medicaid, MLTC, PACE, Medicaid Advantage (MA), MAP, FIDA, FIDA-IDD, CHIP, EP, and Specialized IDD Plans (SIP). The data are submitted by each health plan as frequently as updates to their networks occur and are required to be submitted at least once per quarter. PNDS submission frequency matches the requirements outlined in Insurance Law §§ 3217-a(a)(17), 4324(a)(17) and Public Health Law § 4408(r), and 10 NYCRR 98-1.16(j). A health plan must update their online provider directory, as well as their PNDS submission, within 15 days of becoming aware of the addition or termination of a provider from its network, or a change in a physician's hospital affiliation.

Submissions are divided into two (2) files by health plan submitters: one (1) file lists all individual providers in the network (“provider files”) and another lists all facilities/services in the network (“ancillary files”). All submitted data are validated by the system against reference data and standardized to display consistent name and address conventions. A summary of any issues found during data validation is provided to the health plan by the system for continuous improvement. This summary informs the health plan about the number of rows in their submission that failed to pass various validation steps. For certain fields, the State DOH communicates a passing rate for the proportion of rows that must pass validation, and this threshold is implemented by the contractor as a system update. If the passing rate is not achieved, the file is rejected.

Accepted PNDS data are used primarily to assess plan networks for adequacy, ensuring that the State DOH's standards for provider access and choice are met. Data are also displayed on a public-facing consumer search tool, the State Provider and Health Plan Look-Up ("Look-Up"). The Look-Up allows users to search, without authentication, by provider to find health networks, or to search by health plan/network to find participating providers. Collected data are also used by various programs in different State agencies for research and evaluation; several recurring data extracts that meet the various user needs are required. In addition to recurring extracts, the system must also include a database that allows the State DOH and other administrative users to access collected data through SQL queries and a point-and-click query tool.

Panel Data Overview

The State DOH collects panel data (a file with all plan enrollees and their assigned primary care providers [PCPs]) from MCPs on a quarterly basis. Panel data are submitted by the following MCP types: MMC, HIV-SNP, HARP, CHIP, Aliessa, EP, and QHPs. Panel submissions reflect plan enrollment as of the last week of the quarter and must be submitted in accordance with the panel data dictionary. Panel data support several programs and the State DOH's research agenda. Panel data include information on the member (first name, last name, identifier (CIN, HX ID, CHP ID, auto-assignment status), the PCP (first name, last name, National Provider Identifier [NPI], license number, state of licensure, Medicaid ID) and health plan (plan ID, type of product). Submissions also include row identifiers, as submitted by health plans, and these identifiers, as well as system generated submission IDs, are used for troubleshooting submission issues. All submitted data are validated against reference data and standardized to display consistent name and address conventions. A summary of any issues found during data validation is automatically provided to the health plan by the system for continuous improvement. This summary informs the health plan about the number of rows in their submission that failed to pass various validation steps. For certain fields, per the panel data dictionary, the State DOH sets a passing rate for the proportion of rows that must pass validation. If the passing rate is not achieved, the file is rejected.

PNDS and Panel Data Systems

Both the PNDS and panel data submission processes include: 1) data intake, analysis, communication, and reporting systems, 2) reference data libraries, and 3) system support and analysis. The PNDS also includes a public-facing search tool [https://www.health.ny.gov/health_care/pnds/] which allows consumers to query plan provider networks. The system requirements are detailed below. The system, encompassing all components detailed in this section, will be owned by the State DOH and transferred to a new Contractor at the end of the contract period. The Contractor will work with the succeeding vendor to ensure a successful system transfer.

The Contractor will maintain a data submission system that continuously accepts data and houses reference data and reports. The Contractor will conduct a full assessment of the business, software, hardware and infrastructure environments of PNDS and panel, and develop a plan for any needed development within 90 days of the contract start date. The State DOH will meet with the Contractor to provide an understanding of requirements for PNDS functionality and continued support. Changes will occur that will require the Contractor to handle special processing, including interface revisions and updates, and enhancements and modifications to meet additional federal and State requirements. Within 90 days of the contract start date, the Contractor will submit a change management plan for State DOH approval for the process to submit, review and enact changes. Individual change requests will be provided by the Contractor as a fixed, not to exceed cost based on the hourly rates multiplied by the number of hours provided in the contract budget.

The Contractor will validate plan-submitted data files in real time to ensure the data comply with specifications. If discrepancies are found, the Contractor will work with the State DOH and plan to reconcile the files. The Contractor will provide technical assistance to plans regarding data element formats and submission tool issues.

4.1.3.1 Comprehensive data intake and analysis, communication, tracking, and reporting system

a. Data Intake and Analysis

The Contractor will maintain a data intake portal at a State DOH-approved domain name such as pnds.health.ny.gov. The site must include user authentication, provision user access to the appropriate roles, and meet security protocols (<https://its.ny.gov/ciso/policies/security>) as established by ITS. Panel data contain PHI and PII and the Contractor must ensure that data in the portal are securely collected and stored. Health plans and State staff will create user accounts and user types must be created to assign differing levels of system privileges. The intake system will house reference data to be used during the data validation process, including but not limited to CMS National Provider Identifier (NPI) data, State Education Department licensure data, sanctioned provider lists from multiple sources, health facility license data, acceptable codes lists, and plan enrollment and capitation data. Reference data will be compiled by the Contractor and will require access to the State DOH's DataMart and Medicaid Data Warehouse (MDW), which can be obtained through the DOH's MDW Access Request form and provisioning process.

The Contractor will need information technology staffing (e.g., a programmer) to facilitate data access. The Contractor shall provide a signed copy of a Data Use Agreement (DUA), specifying the data scope, including but not limited to, data elements and date range of the data needed. The Contractor shall provision accounts for authorized users to access the required data in the NYS provided environment in accordance with the terms and conditions of the contract and for the duration of the DUA. Upon award, the Contractor will provide the State DOH, and maintain on an ongoing basis, the list of those users, including name, position, responsibility, and time period, who will require access to the data. The Contractor must review, update, and submit a list of current authorized users to the State DOH quarterly. Additionally, the winning Bidder must notify the State DOH immediately, in accordance with the DUA, when an authorized user joins or separates from the project. The State DOH will authorize users and provision accounts within 30 calendar days of request.

The intake portal must house the list of the health plans that are required to submit PNDS and panel, the products they offer, the counties that they operate in, network names and identifiers, and contact information. Users must be able to edit and export the data within the portal. A history of changes to this list must be accessible to the State DOH.

The intake portal allows for continuous submissions throughout the year, allowing plans to submit sample files ("test files") as well as full final files ("regular files"). Plans are also be able to submit multiple partial files that create a full file when combined, and the system allows for plans to designate when a submission has been completed across multiple files. Plans can manually submit or submit via Application Programming Interface (API). The submission schedule will be quarterly and specified by the State DOH. Changes and edits to the schedule will be done through and housed in the intake portal. All submitted files must be compared to validation data and screened for adherence to submission guidelines as per the PNDS and panel data dictionaries. Only files meeting a certain level of data validation on each critical field will be accepted. The Contractor will receive a list of validation steps and additional validation steps are incorporated into the data intake process as needed. A success and failure report must be created for each submission that allows users to identify errors in their submissions and download data containing errors. A history of the validation that each submission runs through should be retained, and the system should display data as of the time and date the submission began processing, processing time, when the submission was reviewed and approved or rejected by the State DOH. This submission metadata should include functionality that allows uploaders and the State DOH to insert comments that the system retains. The intake system must be updated whenever dictionary changes occur, or whenever the State DOH requires a change to data validation. The Contractor will create a development site to test any site or validation changes before deploying to the production site.

The Contractor must have adequate storage to host a portion of test files and all regular files for at least five (5) quarters. Recent PND data from one quarter used 75 GB of space, representing approximately 300 health plan networks. Recent panel data from one quarter used 12 GB of space, representing approximately 90 health plan-product combinations. The most recently completed regular files (PND provider, PND ancillary, and panel) from each health plan in each quarter must be stored for seven (7) years. By the end of the first year the Contractor must develop a plan to transfer all retained data to the State DOH for archival at the completion of the contract. The Contractor must standardize submitted names and addresses to more uniformly present the data and must provide geocoordinates for submitted addresses. Originally submitted data, as well as standardized data, must be retained. The Contractor will summarize all submitted data into provider and enrollment counts by plan, product, county/region, and specialty, and this summary report will be available for health plan review. PND data accepted through the intake portal must be reviewed for network adequacy. Results of the adequacy analyses must be saved in the intake portal. The system must allow the State DOH to designate that certain PND submissions be analyzed for adequacy on an ad hoc basis, allow comments to be manually attached to that file, and create a history section or report for each file that retains all information related to the file.

b. Communication

The system is capable of sending automated and user-prompted emails to health plans, reminding them of upcoming due dates, notifying them of deficiencies to review, and alerting them of potential issues with their submissions. Important due dates will be displayed on a calendar embedded in the portal, with the ability to restrict access based on user type.

The Contractor will maintain a dashboard within the intake portal that can be updated as needed to convey information to users (e.g., an alert about system issues or a reminder of an upcoming dictionary change). The messages on this dashboard should be easily updated by the Contractor and by the State DOH, and should also have the ability to display scheduled messages for a predetermined duration (e.g., schedule the dashboard to always display a reminder to submit data two [2] weeks before the data are due each quarter and schedule that reminder to disappear on the due date). Select messages on the dashboard should only be visible to certain user types, allowing the State DOH to convey information to administrators only.

c. Tracking

A review of the networks submitted via PND files will result in lists of met and unmet standards (“deficiencies”). The results from these reviews will be stored within the intake portal, and users must be able to see the list of providers that comprise the numerator and denominator for each measured standard. The Contractor will maintain a tracking application that holds PND network adequacy information and allows plans and administrators and the State DOH to communicate with each other about deficiencies, edit existing findings, create new deficiencies, monitor trends in deficiencies over time, and create deficiency reports to be shared with health plans.

The Contractor will maintain an application within the intake portal that allows administrators to flag health plan-reported data as suspicious or inaccurate. Administrators must be able to log suspicions, record findings, and confirm or remove a suspicion. Confirmed suspicions will be used by the Contractor in the validation process, as described below.

d. Reporting

The Contractor must produce several data extracts to be delivered to the State DOH on a recurring basis. The State DOH will communicate the requirements for each extract, including fields to include, and any necessary filters to apply. Specifications may change based on dictionary updates. The Contractor will produce seven (7) extracts on a quarterly or monthly basis, depending on the extract specifications:

- i. Quarterly PND Provider File—a full list of all provider rows from each submitter’s most recently completed submission at the end of the quarter, to include rows determined to be excluded providers (these rows must be flagged). This extract must be uploaded to the DataMart.
- ii. Quarterly PND Ancillary File—a full list of all ancillary rows from each submitter’s most recently completed submission at the end of the quarter, to include rows determined to be excluded providers (these rows must be flagged). This extract must be uploaded to the DataMart.

- iii. Quarterly Panel File—a full list of all rows from each submitter’s most recently completed submission at the end of the quarter, to include rows determined to be excluded providers (these rows must be flagged). This extract must be uploaded to the DataMart.
- iv. Monthly All Payer Data (APD) System PNDS Provider File—a full list of all provider rows from each submitter’s most recently completed submission at the end of the month, to include rows determined to be excluded providers (these rows must be flagged).
- v. Monthly APD PNDS Ancillary File—a full list of all ancillary rows from each submitter’s most recently completed submission at the end of the month, to include rows determined to be excluded providers (these rows must be flagged).
- vi. Quarterly Insure Kids Now (IKN) File—an extract of the most recently submitted PNDS provider data, limited to dental providers in certain lines of business as outlined by the IKN submission specifications.
- vii. Quarterly Maximus File—an extract of the most recently submitted PNDS provider data, limited to certain lines of business as outlined by the Maximus extract specifications.

The extracts will be uploaded to the State DOH using the Medicaid Data Mart and Comma Separated Values (CSV) files will be provided as listed in the specifications for each extract. The Contractor will perform a quality review on all reports prior to submitting them to the State DOH and will provide the State DOH with a summary of findings. The Contractor will develop a web API to share PNDS data to and from the intake system and the State DOH’s APD, or other systems within the State DOH as needed.

The Contractor will make all originally submitted data, as well as standardized data, available to the State DOH through a querying tool. The tool must allow users to execute SQL queries and must allow for point-and-click querying. Results of queries can be downloaded through the tool.

Seventeen (17) data summary reports (listed below) must be made available by the Contractor to the State DOH and must be continuously updated in real-time as new data are collected. Other reports must be developed by the Contractor as needed by the State DOH, including details regarding security scans, system architecture and site analytics, and all reports should be exportable.

- i. Submission Summary Reports—a summary for each submission that displays the number of providers/sites submitted in each specialty, in each county, by product.
- ii. Plan by County Report—a list of all plans (active and no longer in use), the products and networks that they offer, and the active and pending counties for those products.
- iii. Networks Report—a list of all plans (active and no longer in use), and their various networks, network identifiers, and marketing names.
- iv. Contact List Report—a list of all contact email addresses per network.
- v. Exclusion Plan Report—list of all plans and the number of records submitted on PNDS provider, PNDS ancillary, and panel files that matched sites or providers on Exclusions/Sanction data continuously updated throughout the quarter, culminating in a final quarterly report.
- vi. Exclusion Provider Report—lists of all individual providers submitted on all PNDS provider and panel files that matched providers on Exclusion/Sanction data continuously updated throughout the quarter, culminating in a final quarterly report.
- vii. Exclusion Site Report—lists of all sites submitted on all PNDS ancillary files that matched sites on Exclusion/Sanction data continuously updated throughout the quarter, culminating in a final quarterly report.
- viii. Plan Status Report—lists of all plans and their submission status for the quarter continuously updated throughout the quarter, culminating in a final quarterly report.
- ix. Plan Submission Counts Report—list of all plans and a comparison of previous quarterly record counts with current quarterly record counts continuously updated throughout the quarter, culminating in a final quarterly report.
- x. Shared Network Report—lists of all plan networks indicating which networks are shared among plans.
- xi. Submission Status Report—lists of all plans and the status of their PNDS provider and ancillary files, and panel files per quarter continuously updated throughout the quarter, culminating in a final quarterly report.
- xii. Quarterly Total Deficiency Report—lists by network of all PNDS deficiencies logged in the Deficiency Tracking Application

- xiii. Network Adequacy Summary Report—lists by network of all PNDS network review results performed for each analysis.
- xiv. User Report— continuously updated lists of all portal users, their role (privileges), plan associations, and email address.
- xv. Quarterly FTE Report—lists of all plans and the reported counts of full-time employed providers submitted by each via PNDS.
- xvi. Wheelchair Report—counts of providers submitted by each plan, by product and each provider’s wheelchair accessibility, as reported to PNDS.
- xvii. Quarterly Panel Enrollment Comparison Report—lists of panel submitting plans and products, the expected number of enrollees to be submitted by plan (based on enrollment/capitation data) and the number of those members who were submitted in panel data by the plan.

e. Excluded Providers

The Contractor, using lists of sanctioned or otherwise excluded providers, must flag these providers in health plans’ submissions. Sanctioned lists include National Plan and Provider Enumeration System (NPPES) deactivation data, State Education Department inactive license data, CMS’ lists of for-cause terminations from state or federal programs, and adverse action reports from the State Office of the Medicaid Inspector General, the Office of the Inspector General, and OPMC. The excluded providers’ reference data, and list of excluded providers found on submissions, must be available for plans and the State DOH to download.

The State DOH routinely becomes aware of potentially incorrect data being submitted by an MCO (e.g., a provider may be reported with a specialty or address that is incorrect). The State DOH must be able to keep a list of these potential inaccuracies (“suspect provider data”) and log their findings when reviewing the inaccuracy. When the State DOH confirms that the specialty or address is incorrect, these suspect providers become exclusion data, so the system must not allow plans to submit the incorrect information.

4.1.3.2 Reference Data Library

a. Reference and Validation Data

The Contractor will develop and maintain the necessary reference data, including downloadable validation data, exclusion lists, suspect provider logs, user guides, validation rules and plan-submitted reference data, and create a library that houses these data for plans and administrators to access. The Contractor will adhere to a monthly schedule for updating all reference and validation data. If errors or omissions are found on the reference data, the State DOH will direct the Contractor to refresh or modify the data prior to the next scheduled refresh.

b. User Guides

The Contractor will maintain user guides for each user type detailing how to use various applications within the portal, including data submissions, deficiency tracking, suspect provider tracking, and the reporting application.

c. System Edits

The Contractor will keep a library of current and past system validation rules with the begin and end date representing the timeframe that they were in place, enabling users to search submission types (PNDS provider, PNDS ancillary, or panel) and field names and retrieve information on how submitted data in that field are validated. The PNDS and panel dictionaries must also be stored in this library.

d. Plan-Submitted Reference Files

The Contractor will maintain a page on the portal where health plans can upload supplemental information not included in their submission. Each health plan must have their own dedicated space that other non-administrator users cannot access.

4.1.3.3 PNDS Look-up Search Tool

The NYS Provider & Health Plan Look-Up was launched in 2017 as an online tool that puts information about health plan provider networks all in one place. Consumers can search for a provider by name to see a list of the health plans they participate with and can search a health plan to see a list of providers in the plan’s network. Additional filters, such as product, provider specialty, zip code, and language spoken can be used to refine results. Plan-submitted PNDS data are used to populate this tool.

a. Functionality

The Contractor will maintain a Look-Up site at <https://pnlookup.health.ny.gov/> (or another State DOH-approved domain). The Look-Up tool will display PNDS-collected data in a consumer-friendly format. The tool must allow users to search either by provider/facility, by health plan, or by product (e.g., Medicaid, EP, CHIP). Users must be able to search using, at a minimum, the following information: partial name, practice name, address, zip code, county, specialty, language, wheelchair accessibility, gender, primary care designation, health plan, and product/line of business. Results must be available in a printable format. Data displaying in the Look-Up should link to outside sources relevant to the consumer, including maps for location, NYSOH, and publicly available provider information.

The Contractor will maintain a contact page within this site that allows users to report inaccuracies in the data. The Contractor will maintain a feedback loop that directs the inquiry/report to the relevant health plan(s) and to the State DOH. The Contractor must log all inquiries/reports and make this log available to the State DOH on a weekly basis.

The Look-Up must also house pages for frequently asked questions, information about the data, user guides and/or tutorials supplied by the State DOH, and information about the tool in multiple languages. The Look-Up and all its functionality must be fully available in English and Spanish languages.

b. Refresh Frequency

The Contractor must refresh the data on the Look-Up on a daily basis. The Contractor will use a development site to display and test each refresh before deploying to the production site. The data must reflect the most recently approved submissions from each health plan. The Contractor will manipulate the data so that consumers may easily search and compare health networks; this includes combining submissions to appear under one (1) health plan name, using external data, display plan names and de-coded specialty names, grouping specialties into searchable terms, and updating contact email addresses used in the Look-Up's contact page. The Contractor will make updates to the site in terms of display, functionality, and content on a weekly basis if needed by the State DOH.

c. Quality Assurance

The Contractor will conduct reviews of the Look-Up tool's functionality to ensure that each refresh is appropriately displayed, results match intake system submission results, information is displaying correctly in both English and Spanish languages, and that the contact page is working appropriately. The Contractor will submit a quality review report to the State DOH on a weekly basis that details the number of providers per plan that were uploaded into the Look-Up as well as a review to confirm that all plan names and content are displaying as intended.

4.1.3.4 System Support and Analysis

a. Architecture

The Contractor must supply a system architecture document to the State DOH and work with ITS to ensure system architecture meets prescribed standards (<https://its.ny.gov/tables/technologypolicyindex>; <https://its.ny.gov/ciso/policies/security>).

b. Technical Support and Reminders

The Contractor must create a support ticketing system that allows system users to submit questions or report system issues. The Contractor must troubleshoot issues with users, de-bug systems, and use the reported issues to recommend system changes and upgrades. The Contractor will build functionality for automatic reminders to go to all users when deadlines are approaching.

c. Security Scan

At least once annually, the Contractor must contract with a third party to perform a full vulnerability scan on all PNDS and panel-related systems. Findings and recommendations must be reported to the State DOH. The solution must remain compliant with NYS ITS Security Policies and the Contractor must perform remediations or mitigations at the sole discretion of NYS.

d. Analytics

The Contractor must make statistics about the utilization of the PNDS/panel and related sites available to the State DOH on a monthly basis, including but not limited to site hits and duration, user counts, and bounce rates.

e. Project Management

The Contractor will use project management software to track requested system edits. The Contractor and the State DOH will collaboratively use the software to define needed changes, track progress on these changes, and assign and prioritize work. Tasks will be categorized as minor (i.e., changes to displays, wording updates, updates to validation thresholds), moderate (i.e., changes to data validation rules including new reference data and logic on matching to the data; modifications to and request for new reports and exports) or major (i.e., substantial re-mapping of portal pages and communication between pages, changes to the file layout). Minor tasks must be completed within one (1) month, moderate tasks must be completed within two (2) months and major tasks must be completed within three (3) months.

4.1.4 Sepsis Care Improvement Initiative

Effective May 1, 2013, Title 10 NYCRR Sections 405.2 and 405.4 were amended to require that hospitals have in place evidence-based protocols for the early recognition and treatment of patients with severe sepsis and septic shock that are based on generally accepted standards of care. The submission of updated, evidence-based sepsis protocols upon request, not more frequently than every two (2) years, is a continuing requirement of Section 405.4. The State DOH is responsible for overseeing this statewide initiative to reduce inpatient sepsis mortality rates. The initiative requires the collection of clinical data from all hospitals in the State to evaluate compliance with protocols using standardized measures and risk adjusted mortality (adults), and other relevant outcome measures for children. These data will be used for public reporting and for quality improvement activities.

The Contractor will facilitate the continued efforts of the Sepsis Care Improvement Initiative through the following activities:

4.1.4.1 Development and Maintenance of Data Intake System

Beginning in 2014, all State Article 28 hospitals were required to report data to the State DOH that are used to calculate each hospital's performance on key measures of early treatment and protocol use. Hospitals are required to submit data on a quarterly basis.

The Contractor will develop or revise a secure, HIPAA compliant, user friendly web-based data collection/submission portal and database for each calendar year. The portal design and structure should be able to handle both pediatric and adult data submissions from separate data dictionaries and be flexible to accommodate any future changes to the data dictionary. The portal should provide notification to the user of a successful upload. The portal and database design should be able to handle case level modifications and deletions and maintain the log of changes and the portal and/or database should have a capability to accommodate simple stratified sampling for select hospitals with ability to maintain replacement cases (when a previously sampled case is not deemed to be a severe sepsis case after a clinical review, a replacement case should be provided to the hospital).

The Contractor will provide technical assistance to users of the portal, provide appropriate maintenance for the data collection system to ensure consistency with new data dictionaries and to address system issues as they arise and in anticipation of changes, and develop a tool to be utilized by hospitals for data abstraction with built in skip patterns and logic.

4.1.4.2 Quarterly and Annual Reporting Requirements and Data Submission Review and Validation.

State Article 28 hospitals are required to submit all cases of severe sepsis or septic shock to the State DOH on a quarterly basis, including those cases that were transferred and the treatment provided prior to or after transfer. Starting in 2017, high volume hospitals were allowed to utilize sampling for the sepsis data reporting.

The Contractor will provide ongoing technical assistance to hospitals on a variety of issues connected to quality performance data collection and validation and serve as a liaison between the hospitals and the State DOH. The Contractor will organize and participate in periodic sepsis advisory group calls, a biannual, one (1) hour conference call with WebEx capability with hospitals and a biannual, one (1) hour conference call with WebEx capability with abstractors. Agenda topics for these meetings will include discussion of changes in data submission, audit procedures, measure calculations and specifications.

Hospitals are also required to submit sufficient clinical information on each patient with sepsis to allow the State DOH to develop a methodology to calculate 'risk adjusted' mortality rates for each hospital. Risk adjustment permits comparison of hospital performance and takes into consideration the different mix of demographic and comorbidity attributes, including sepsis severity of patients cared for within each hospital. The Contractor should have the ability to prepare and securely distribute reports in a Tableau dashboard format and/or with a similar data visualization tool to report back to hospitals their performance on measures and attributes collected and/or calculated by the Contractor or the State DOH.

At least twice per year to align with federal sepsis data collection updates from CMS, and up to four (4) times per year as the State DOH determines changes are needed, the Contractor will prepare and update measure specifications, prepare and maintain a data dictionary for each calendar year or as needed to accommodate changes throughout the calendar year, and maintain the log of changes and make it available on the Sepsis Initiative website. The Contractor will also monitor the CMS data dictionary for changes for incorporation and alignment with the State DOH's data dictionary. The Contractor will adopt the existing data dictionary, and in addition, will maintain and make publicly available the codes (including but not limited to ICD-10-CM, ICD-10-PCS, Healthcare Common Procedures Coding System [HCPCS], and National Drug Codes [NDCs]) selected by the State DOH that are required to be collected by hospitals.

The Contractor will analyze data to identify hospitals that submitted data without a unique patient record or with inclusion of overlapping admission and discharge dates, or with any other inconsistencies in the data. From this analysis, the Contractor will generate a hospital exception report and correct the files while maintaining the log of changes that are shared with the State DOH.

The Contractor will develop and implement a data validation process within the first three (3) months of contract execution for quarterly data, including identification of specific variables and the number of medical charts to validate while minimizing the burden on hospitals. The Contractor will enable and facilitate submission of targeted and/or complete medical records and validate 10% of cases and identify and report findings for variable with inconsistent abstraction to the State DOH. The records are to be reviewed by an RN and escalated to a review by a physician, according to a protocol developed and put in place by the Contractor. The Contractor will develop a quarterly report for hospitals which includes the rationale for elements that are not validated and facilitate bidirectional communication for frequently observed discrepancies, maintain the log and keep the State DOH informed. The Contractor will identify and maintain a current list of primary contacts at the hospitals for email notification of non-compliance and send a notice of non-compliance to the hospital when reporting is not completed. The Contractor will provide technical and clinical assistance to hospital abstractors and clinical staff on validation discrepancies.

The Contractor will analyze quarterly hospital performance data and prepare and distribute quarterly reports to each hospital. The Contractor, in conjunction with the State DOH and the hospitals, may also be asked to develop and monitor quality improvement strategies related to sepsis results.

The Contractor will provide the State DOH with a final data set of all records, upon completion of data validation, as they are submitted by the hospitals (with data inconsistencies) and a data set with resolved data inconsistencies for the State DOH to prepare a risk adjustment analysis with specifications developed by the State DOH. The Contractor will provide the State DOH with up to one (1) additional data set per quarter with specifications provided by the State DOH, and with the ability to provide data in a variety of formats, including Microsoft Excel, PowerPoint and/or Tableau as requested. The Contractor will provide the State DOH with all SAS, SQL or other coding language programs used for resolving the data inconsistencies, measure calculations and creation of other data sets that were requested by the State DOH.

The Contractor will prepare a comprehensive dataset which includes data from all reporting hospitals in the State for the measurement year for an annual draft public report and preview release to hospitals.

4.1.4.3 Development and maintenance of a sepsis landing page with help desk feature.

The Contractor will develop and maintain the Sepsis Initiative landing web page as a resource repository for sepsis communication with hospitals, with historical information as well as recently released communications to hospitals. The landing page will have the current data dictionary as well as older versions, a log of changes for data dictionaries, archived webinars, frequently asked questions, a help desk feature with a ticket answering system, measure specifications and log of changes, and a link to the data submission tool.

4.1.5 State Health Profiles: Hospitals, Nursing Homes, Home Care, Hospice, and Adult Care Facilities

Since 2006, the State DOH has produced the "NYS Health Profiles" website (<https://profiles.health.ny.gov/>) highlighting key administrative, quality, and inspections data. The website currently includes information about hospitals, nursing homes, home care agencies, hospice, and adult care facilities in the State.

The Contractor will develop, host, implement, maintain and update a consumer-friendly website, with a database driving functionality on the website, that includes generally accepted quality metrics, administrative data, inspections, and other data as required by the State DOH. Other data includes methodology sections, supplemental documentation, descriptive "about" pages, and links to other websites (under "other providers" tab), such as: links to Health Data NY resources, links to State DOH public website resources, NYS Health Connector, NY Doctor Profile, and Provider Network/Plan Look-up Tool.

The Contractor will develop and maintain the data, including architecture for data sharing across applications or other platforms (for example, Health Data NY [<http://health.data.ny.gov>], the State's Open Data portal). Upon request and within one (1) week, the Contractor will transfer to the State DOH the following, including but not limited to: methodology or code related to architecture, cross-platform sharing, maintenance, data or coding updates, or analytics. The Contractor will maintain data submission list serves or another process to manage the monthly and quarterly data submission processes, working with staff within the State DOH, including requesting data from and resolving issues with the data owners, under the direction and supervision of the State DOH contract manager.

The Contractor will provide adequate and necessary hardware, software and bandwidth and display on-demand profiles that are compatible with all desktop and mobile web browsers, ensuring uptime and availability of services without interruption. All code and interfaces must comply with relevant standards, including State ITS policies and federal Information and Communication Technology (ICT) Standards and Guidelines, Section 508 related to accessibility standards.

Processes will be automated to update and maintain current data, oversee updates and perform quality assurance checks. Automation will involve processes such as Matillion and SAS processes for data updates and quality checks. The routine update and maintenance process will be managed and initiated automatically by the Contractor, with oversight by the State DOH contract manager. For example, with pre-approval from the State DOH contract manager, the Contractor automatically initiates each quarterly update by sending e-mails to State DOH data submitters, outlining the data needed and due dates. This is to be started by the Contractor per the agreed-upon quarterly data and coding update schedule.

The Contractor will determine additional data sources, design elements, programming and metadata necessary for enhancements and ensure continuity of current website document storage. The Contractor will develop and update data and coding schedules and disseminate information and monthly progress reports. The information provided on the website will be easy to use and accessible to the public. The Contractor will maintain a mechanism to receive questions from users (e.g., email or help desk feature).

The website will continue to expand the detailed information on the provider types specified above, including the quality of care they provide. The database and website will allow for consumer-directed queries/filtering that display data geographically via maps and tables; and allow users to print and send results via e-mail by region, county, name, alphabetical browsing, and other criteria as required. The Contractor will continue to incorporate mapping and geocoding for provider-level maps and a quality grading system, including map improvements to ensure they are consumer friendly.

Specific searches, queries, and filtering requirements must include:

- Each profile type must offer several ways to locate a specific provider. This applies to all current provider types including, but not limited to hospitals, nursing homes, home care, adult care, and hospice.
- There must exist a search box that accepts partial or full search terms and returns results.
- There must be a way to search by county/region, services, and alphabetically.
- There must exist a way to select providers and compare them against each other, and against State and national score on various quality and utilization measures. This is called the "My Providers" functionality on the current website.
- There must be a searchable map, currently known as "Providers Near You," by zip code or location. The search results will be added to "My Providers" for comparison purposes.
- Users must have a way to print and save all search results to an exportable CSV format report.

The database and website will allow for consumers to compare quality metrics and other metrics related to maternity and/or hospital procedures. The Contractor will assess and identify the universe of potential quality and safety measures, and evaluate specific parameters such as timeliness, consistency with national measures, and utility. The Contractor will add new measures, metrics and other information as they become available and according to the State DOH's specifications and guidelines. The database and website will continue to be designed and maintained in a way that allows for future addition of quality data, inspection data, and other types of data for provider types and areas. The database must also calculate metrics as directed by the State DOH, including overall ratings or other aggregate statistics.

Specifically, the database must have the capability to ingest public performance data from various sources and applies routine business logic to all incoming data. The incoming data must be converted to a normalized format that easily allows the addition, modification, or removal of data intended for reporting. The database must be capable of comparing metrics for all provider types and reporting that data out in an easily searchable and viewable format.

Examples include, but are not limited to:

- Hospital-acquired infections, mortality, maternity, surgery, and surveillance results
- Nursing home overall ratings, domain ratings, and surveillance results
- Home care agency quality metrics and inspections
- Hospice quality metrics and inspections
- Adult care facility inspections

The Contractor will manage ongoing projects for short cycle rapid development, including a frequent product review and consumer feedback mechanism, including quick response for off-schedule updates.

The "NYS Health Profiles" website must be "mobile-compatible" and be accessible from desktop and mobile devices, correctly displaying all content.

The Contractor will research other state and national websites and provide recommendations on best practices for adhering to industry standards and consumer expectations for updating existing information and implementing enhancements, based on customer demand (State DOH and public) and market conditions.

4.1.6 Special Studies, Quality Assistance, and Improvement Projects

The Contractor will be expected to support new and ongoing quality improvement activities related to the mandatory and optional activities described in this RFP as well as for new areas that may require attention during the term of this contract. Previous examples of work in these areas that is now incorporated into this RFP, are: Sepsis Initiative; Hospital Profile, Nursing Home Profile, Home Health, and Hospice Profile; and Office Based Surgery.

Centering Pregnancy

In an effort to help improve birth outcomes and maternal-child health in NYS, the Medicaid program established the First 1000 Days on Medicaid initiative. This initiative consists of 10 priority action items/projects that the State DOH must implement to help improve the care and welfare of children, ages 0–3, in Medicaid. One of the 10 priority action items/projects of the NYS First 1000 Days on Medicaid initiative is to establish a Centering Pregnancy pilot project (Proposal # 4 in the link below):

https://www.health.ny.gov/health_care/medicaid/redesign/1000_days/2017-11-09_proposal_desc.htm

The Centering Pregnancy model of care is an evidenced-based model of delivering prenatal care that is aligned with the American College of Obstetrics and Gynecology (ACOG) standards. Under the Centering Pregnancy model of prenatal care, group visits, with obstetric clinicians, made up of 8–10 women who are due to deliver their babies at approximately the same time, are held in coordination with traditional 1-on-1 prenatal care visits.

The Centering Pregnancy model of care is overseen by the Centering Healthcare Institute (CHI), a national not-for-profit organization that developed the Centering Pregnancy model of care and maintains the standards of its practice, which are aligned with ACOG's standards of care. CHI licenses and accredits the obstetric clinics who choose to provide the Centering Pregnancy model of care in their practices, alongside the traditional model of prenatal care. CHI also provides the obstetric provider practices with the education and training needed to implement a Centering Pregnancy model of care at their sites.

The goal of this Centering Pregnancy project is to evaluate the impact of expanding access to the Centering Pregnancy model of prenatal care in areas known to have poor birth outcomes in NYS to help improve outcomes on two (2) key measures: rates of low birth weight and rates of preterm birth.

Phase 1 of the Pilot includes expanding provider practice sites that currently participate in the Centering Pregnancy model of prenatal care. Phase 2 includes establishing new Centering Pregnancy models of prenatal care at provider practice sites. The Data Analysis Plan, a Roster of members and a data collection tool that the provider practices use will be developed. In addition, data collection tool instructions and specifications will also be developed. These materials will be shared with the Contractor.

The Contractor will:

- Provide participating provider practices with access to a secure HIPAA compliant pathway for sharing pilot materials containing PHI.
- Send a Roster to the provider practice for completion by the practice monthly.
- Receive monthly Rosters with members from participating practices through a secure HIPAA compliant pathway.
- Send a cumulative Roster to the State DOH, through a HIPAA compliant pathway, for validation of enrollment in MMC plan.
- Send the participating practices, through a secure HIPAA compliant pathway, a data collection tool for each member to be completed by the provider practice.
- Receive completed data collection tools from the provider practices through a secure HIPAA compliant pathway.
- Provide follow-up with provider practices on any outstanding reporting that has not been submitted.
- Provide technical support to provider practices on data collection activities.
- Prepare a monthly tracking report, to be shared with the State DOH, summarizing the activity with the provider practices.
- Compile a central repository of the submitted data from all provider practices.

- Conduct data analysis and prepare a draft Final Report.
- Works with the State DOH to finalize the Final Report.

Doula surveys

Background:

The State DOH launched a pilot expansion of the State's Medicaid program to cover doula services for Medicaid FFS and MMC enrollees. The Medicaid pilot program will be implemented through a phased-in approach in order to ensure access to this new benefit. Phase 1 of the pilot launched in Erie County on March 1, 2019. The State DOH continues to work with doulas in Kings County to enroll as Medicaid providers and Phase 2 of the pilot will launch in Kings County when provider capacity is reached. The doula pilot is a part of the State's multi-pronged initiative to target maternal mortality and reduce racial disparities in health outcomes. A doula is a non-medical birth coach who assists a woman during the prenatal period, labor, delivery, and post childbirth.

Research suggests the use of a doula may have a positive effect on health outcomes. The pilot will focus on Erie and Kings Counties which have among the highest maternal and infant mortality rates and largest number of Medicaid births in New York State. The New York State Medicaid Program will reimburse participating doulas for up to four (4) prenatal visits, support during labor and delivery, and up to four (4) postpartum visits.

The DOH will evaluate the doula pilot for reach, effectiveness, and doula and member satisfaction. Maternal outcomes will include breastfeeding rates and adherence to postpartum visits. Two (2) surveys will be given to both doulas and the members they serve. Doulas will receive the first survey after their first three (3) claims have been reimbursed and the second survey at the end of the pilot. Members will receive the first survey four (4) to six (6) weeks after childbirth and the second survey around three (3) months after childbirth.

The Contractor will:

- Administer a mailed survey to Medicaid members who participate in the doula pilot project. The doula pilot project started on 3/1/19.
 - Surveys for members are on breastfeeding rates and satisfaction with the program. The survey is administered at least twice postpartum.
- Collect mailed surveys and input data into a spreadsheet.

Multisystem Inflammatory Syndrome in Children (MIS-C)

Children have been significantly less affected by COVID-19 than adults, as only one percent (1%) of New Yorkers who have been hospitalized were under 20 years old. However, the State DOH is investigating cases of Multisystem Inflammatory Syndrome in Children (MIS-C) in New York of predominantly school-aged children experiencing symptoms similar to Kawasaki disease and toxic shock-like syndrome, possibly due to COVID-19. Of the children displaying these symptoms, 97 percent (97%) tested positive for COVID-19 either by diagnostic, antibody testing or both. Though most children who get COVID-19 experience only mild symptoms, MIS-C has features which overlap with Kawasaki disease and toxic shock syndrome and may occur days to weeks after acute COVID-19 illness. Health care providers, including hospitals, are required to report to the State DOH all cases of MIS-C potentially associated with COVID-19 in those under 21 years of age.

The Contractor will facilitate data collection of MIS-C cases for the State DOH through the following activities:

- Adopt the current MIS-C Dictionary and the existing MIS-C redcap tool;
- Obtain medical records (receive old; request new; request incompletes);
- Abstract data from medical records;
- Maintain MIS-C Registry using abstracted data;
- Manage a Helpdesk system: receive tickets and respond to all for clinical/technical questions;
- Prepare and distribute data/reports to the State DOH at least weekly and as needed and provide the State DOH the ability to directly export data as needed.

Consultant Review Services

The Contractor will provide the State DOH with consultant services for the review of care provided to Medicaid enrollees, medical services provided in Article 28 facilities, as well as conduct special studies and projects, and provide physician and medical consultant services to the State DOH as required to support the State DOH's overall quality of care and surveillance responsibilities. Examples of reviews to be conducted may include review of appropriate hospital billing to MMC plans, review of complaints filed by Medicaid managed care enrollees to the State DOH that require a clinical record review, additional database validations, development of clinical standards/guidelines, other technical assistance, trainings or conferences.

The Contractor will also provide, upon request, consultant services to support and evaluate Medicaid program audits and reviews of services paid for under the program, including but not limited to, Durable Medical Equipment, Dental Services, Clinic Services, and other types of services as required by the State DOH.

For example, when a complaint is filed alleging that the clinical criteria used by the MCO to determine medical necessity of a service or treatment is inconsistent with national standards and/or acceptable medical practice, the State DOH may collect documentation of the clinical criteria and policies for authorization and request Contractor review. The Contractor must assess the potential for conflict of interest with other contracted responsibilities, e.g., as an independent external appeal agent, prior to accepting the case in question. If accepted, the Contractor will review the criteria to determine the extent, if any, the criteria deviates from national standards and/or acceptable medical practice, recognizing that an MCO is not required to accept or account for all theories or protocols of treatment, but may for quality purposes align their criteria with a particular acceptable standard of care or treatment protocol. The Bidder should anticipate up to five (5) case reviews of this type per year.

The State DOH requires MCOs to adopt clinical standards consistent with current standards of care and in compliance with recommendations of professional specialty groups. The State DOH has further developed standards/guidelines that apply to the Medicaid population including clinical standards for adult, adolescent and HIV pediatric care, statewide asthma care guidelines and prenatal care standards. The Contractor will provide consultation when new guidelines need to be developed. Work activities required for the Contractor could also include assistance in the execution of research activities including technical and programmatic support, researching clinical literature for evidence-based current standards of care and recommendations of professional specialty groups, facilitating collaborative meetings/conference calls with an invited clinical expert advisory panel, preparing draft and final guidelines and disseminating guidelines to relevant provider groups in NYS.

At the time of this RFP, all future work has not been determined; however, additional work may be required by the State DOH as it relates to: bioterrorism issues; general chronic disease conditions affecting public health; natural disasters, infectious disease outbreaks, as well as providing expert medical testimony in judicial proceedings (for example, Medicaid fair hearings) resulting from review determinations and outlier Medicaid reviews involving special projects or topics. The Bidder should understand that any unanticipated work will necessitate reductions in other parts of the work plan and as such, will not result in a change to the total contract award.

4.2 Staffing

Success for the scope of work summarized in this RFP will rely on an effective organizational structure and highly productive, motivated and qualified staff. Overall staffing must adequately meet the scope of work and deliverables. The Contractor must ensure that each project is adequately staffed with experienced, knowledgeable staff. Given the scope of services and complexity of the Medicaid program in the State, it is essential that adequate supervisory staff, in terms of experience and number, is in place to manage the deliverables described in this RFP. The Contractor is required to have a full-time (30 hours per week or greater) project manager who will assure effective communication and coordination of the contract scope of work including integrity of all products throughout the course of the contract period. The Contractor is also required to have a technical writer who will assure that all written products are professionally prepared, clear, accurate and meaningful.

Clinical staff, including physicians and nurses, are needed to provide many of the functions required in this contract, such as medical record reviews, development of medical record abstraction tools, analysis of clinical standards and guidelines, conducting focused clinical studies, clinical data validation, PIP validation and preparation of reports and presentations. The Contractor's organization must be composed of, or have available, the services of licensed doctors of medicine, osteopathy, and other health care professionals, including licensed Pharmacists with the experience and training necessary to conduct the required review activities including staff with demonstrated experience and knowledge of Medicaid benefits, policies, data systems and processes, managed care delivery systems, quality assessment and improvement methods, and expertise in research and study design. Candidates must be in good standing with preference given to those licensed in New York State.

Knowledge and experience in primary care (family practice, internal medicine, pediatrics, OB/GYN and/or public health) is required. Other staff qualifications will include expertise in data analysis, computer programming, medical coding, statistical analysis, survey design and administration, technical report writing, information technology, and the ability to organize and/or conduct quality improvement trainings and conferences. Clinical staff must hold and maintain a current and valid license to practice in their profession. Physicians and RNs involved in the quality improvement projects must be experienced in conducting evidence-based quality improvement studies.

The Contractor will be responsible for any training required for physician and non-physician reviewer staff in understanding the following:

- The State DOH's review system including the State DOH's goals and objectives for conducting utilization review
- State DOH regulations, policies, and procedures regarding Medicaid coverage for hospital, clinic, home health care, and primary care
- How to conduct medical record reviews and how to abstract information necessary to make a determination from the medical record, including Diagnostic Related Group (DRG) coding
- How to prepare a case decision abstract
- How to incorporate guidelines and standard practices into review activities
- How to perform internal quality control monitoring and training to ensure accuracy and consistency in conducting medical reviews
- How to conduct evidence-based quality improvement projects

The Contractor must also ensure that adequate staff is available and trained to conduct research and data analysis. The Contractor will have or will hire staff in sufficient numbers and possessing technical skills to accommodate the needs of the program including staff skilled in research and study design, data analysis, computer programming, information technology and development of web-based tools, statistical analysis, survey design and administration, technical report writing, and ability to organize and/or conduct quality improvement trainings and conferences.

The Contractor may subcontract with other organizations to perform activities described in this RFP. All subcontractors must be approved by the State DOH.

Within 30 calendar days of notice of award, the Selected Bidder will submit resumes of the staff proposed in the staffing plan for review and approval of the State DOH. In the event that a staff member becomes unavailable during the contract period, the Contractor will submit resumes within 10 business days of notification of the staff unavailability to the State DOH for review and approval prior to engaging work from the replacement on this contract. Within 30 calendar days of notice of award, the Contractor will also submit an updated organizational chart, depicting each functional unit of the organization with their manager's name and title, and the units' relationship with the subcontractors; any revisions should be submitted to the State DOH within 10 business days of the change.

4.3 Written Reports, Data Systems and Data Security

The Contractor will prepare formal reports to summarize the end of projects such as, but not limited to PIPs and Focused Studies. The reports will be posted to the State DOH web site and therefore should be written for a wide audience. The Contractor will provide the State DOH with an outline of the report within 15 business days of the completion of data analysis. The State DOH will provide comments on the outline and work collaboratively with the Contractor to finalize the outline. The reports will include the following sections: Executive Summary, Introduction, Methods, Results, Summary of Findings and Recommendations for consideration by the State DOH and its Medicaid providers. A first draft of a report is due three (3) months following approval of the outline. A final draft, incorporating State DOH comments to the first draft, is due four (4) months following the receipt of State DOH comments. The Contractor may provide additional drafts of the reports throughout the process upon agreement with the State DOH.

The Contractor must maintain computer and data collection system(s), including hardware and software used for each project area and employ staff for information system support, programming, and online support. The system must be able to support required tasks related to case selection, reporting, medical record retrieval (including the use of electronic health records), profiling, and analysis as described in this RFP and attachments. The system must maintain the ability to accept data files in a variety of formats from providers and field staff.

The Contractor's data processing system must provide for data backup and recovery. Disaster planning for off-site secure storage of files and a plan for offsite operation in case of a building disaster is required.

It is expected that the system will operate primarily using administrative data from the State DOH, such as Medicaid billing and encounter systems, and the results of the Contractor's review determinations. In order to access Medicaid client data, a Data Exchange Application and Agreement (DEAA) with the State DOH will be required. Medicaid claims will likely compose the universe from which samples of cases are selected.

In order to maintain data security, the Contractor's data processing system should incorporate:

- Staff training
- Protection of the individual's privacy, including compliance with HIPAA requirements
- Physical security
- Screening process for employees
- Passwords

The Contractor will be required to provide reports to the State DOH on its activities, including reports that involve the denial of Medicaid reimbursement, as outlined in this RFP, and to document for payment of services. The Contractor agrees to participate in the following monitoring and reporting responsibilities within the timeframes indicated:

- a) Collect, organize, and manage data to provide information resources sufficient to operate, manage, and monitor a statewide initiative as set forth in this RFP.
- b) Prepare management reports and information which present the information and reports specified in the contract scope of work.
- c) Participate in monthly scheduled conference calls with lead State DOH staff to review expenditures and progress of the Contractor's responsibilities for the period.
- d) Attend up to four (4) in person meetings in Albany, New York to review findings and report on operations.
- e) Conduct oral presentations of study findings and results to MCOs through webinars, conference calls and in-person as required.

The State DOH reserves the right to request statewide, regional, or provider-specific findings and information at any time, as needed to meet management information needs. All reports shall be provided in an electronic format acceptable to the State DOH.

The Contractors' reports are expected to be written professionally, accurately and by staff who are proficient with technical writing.

4.4 Information Technology

The application and all systems and components supporting it, including but not limited to any forms and databases that include Personal Health, Personal Identification or other State information, must comply with all State security policies and standards listed at <http://its.ny.gov/tables/technologypolicyindex.htm>.

4.5 Security

The selected Contractor shall comply with all privacy and security policies and procedures of the State DOH (<https://its.ny.gov/eiso/policies/security>) and applicable State and federal law and administrative guidance with respect to the performance of this contract. The Contractor is required, if applicable, to execute a number of security and privacy agreements with the State DOH including a Business Associate Agreement (BAA) (Appendix H) and a DUA at contract signing.

The Contractor is expected to provide secure and confidential backup, storage and transmission for hard copy and electronically stored information. Under no circumstances will any records be released to any person, agency, or organization without specific written permission of the State DOH. The Contractor is obligated to ensure any subcontractor hired by the Contractor who stores, processes, analyzes or transmits Medicaid Claims Data on behalf of the Contractor has the appropriate security requirements in place. The Contractor is required to include in all contracts and BAAs with their subcontractors' language surrounding the security and privacy requirements as well as the language contained in the Confidentiality Language for Third Parties section of the DUA. If any breach or suspected breach of the data or confidentiality occurs, whether the breach occurred with the Contractor or subcontractor, the State DOH must be notified immediately.

The Contractor is required to maintain and provide to the State DOH upon request their data confidentiality plans and procedures for meeting security requirements as they relate to the deliverables and services within this RFP, including all plans as they relate to subcontractor work where applicable.

The Contractor will develop and maintain adequate fully trained staff to respond to all stakeholder inquiries while protecting confidentiality and maintaining the security and integrity of all systems. Staff must be trained to understand and observe requirements related to confidentiality and operating guidelines for functions included in this RFP.

The Contractor will produce a review of compliance with policies and discuss any proposed mitigations to found vulnerabilities and corresponding implementation timelines.

4.6 Transition

The transition represents a period when the current contract activities performed by the Contractor must be turned over to the State DOH, another State agency agent or successor Contractor during or at the end of the contract.

The Contractor shall ensure that any transition to the State DOH, State DOH agency or successor Contractor be done in a way that provides the State DOH with uninterrupted services. This includes a complete and total transfer of all data, files, reports, and records generated from the inception of the contract through the end of the contract to the State DOH or another State DOH agent should that be required during or upon expiration of its contract.

The Contractor shall provide technical and business process support as necessary and required by the State DOH to transition and assume contract requirements to the State DOH or another State DOH agent should that be required during or at the end of the contract.

The Contractor shall manage and maintain the appropriate number of staff to meet all requirements listed in the RFP during the transition. All reporting and record requirements, security standards, and performance standards are still in effect during the transition period.

The Contractor is required to develop a work plan and timeline to securely and smoothly transfer any data and records generated from the inception of the contract through the end of the contract to the State DOH or another State DOH agent should that be required during or upon expiration of its contract. The plan and documentation must be submitted to the State DOH before the end of the first contract year and then be updated on an annual basis.

5.0 ADMINISTRATIVE INFORMATION

The following administrative information will apply to this RFP. Failure to comply fully with this information may result in disqualification of your proposal.

5.1 Restricted Period

“Restricted period” means the period of time commencing with the earliest written notice, advertisement, or solicitation of a Request for Proposals (“RFP”), Invitation for Bids (“IFB”), or solicitation of proposals, or any other method for soliciting a response from Bidders intending to result in a procurement contract with the State DOH and ending with the final contract award and approval by State DOH and, where applicable, final contract approval by the Office of the State Comptroller.

This prohibition applies to any oral, written, or electronic communication under circumstances where a reasonable person would infer that the communication was intended to influence this procurement. Violation of any of the requirements described in this Section may be grounds for a determination that the bidder is non-responsible and therefore ineligible for this contract award. Two (2) violations within four (4) years of the rules against impermissible contacts during the “restricted period” may result in the violator being debarred from participating in State DOH procurements for a period of four (4) years.

Pursuant to State Finance Law §§ 139-j and 139-k, the State DOH identifies a designated contact on the face page of this RFP to whom all communications attempting to influence this procurement must be made.

5.2 Questions

There will be an opportunity available for submission of written questions and requests for clarification with regard to this RFP. All questions and requests for clarification of this RFP should cite the particular RFP Section and paragraph number where applicable and must be submitted via email to ogps.asu@health.ny.gov. It is the bidder’s responsibility to ensure that email containing written questions and/or requests for clarification is received at the above address no later than the Deadline for Submission of Written Questions as specified in [Section 1.0](#) (Calendar of Events). Questions received after the deadline may **not** be answered.

Questions and answers, as well as any RFP updates and/or modifications, will be posted on the Department’s website at <http://www.health.ny.gov/funding/> by the date listed on the cover page Schedule of Key Events. There will not be a bidder’s conference in conjunction with this RFP.

5.3 Right to Modify RFP

The State DOH reserves the right to modify any part of this RFP, including but not limited to, the date and time by which proposals must be submitted and received by the State DOH, at any time prior to the Deadline for Submission of Proposals listed in [Section 1.0](#) (Calendar of Events). Modifications to this RFP shall be made by issuance of amendments and/or addenda.

Prior to the Deadline for Submission of Proposals, any such clarifications or modifications as deemed necessary by the State DOH will be posted to the State DOH website.

If the bidder discovers any ambiguity, conflict, discrepancy, omission, or other error in this RFP, the Bidder shall immediately notify the State DOH of such error in writing at ooqs.asu@health.ny.gov and request clarification or modification of the document.

If, prior to the Deadline for Submission of Proposals, a bidder fails to notify the State DOH of a known error or an error that reasonably should have been known, the bidder shall assume the risk of proposing. If awarded the contract, the bidder shall not be entitled to additional compensation by reason of the error or its correction.

5.4 Payment

The Contractor shall submit invoices and/or vouchers to the State's designated payment office:

Preferred Method: Email a .pdf copy of your signed voucher to the BSC at: AccountsPayable@ogs.ny.gov with a cc to OQPSbsc@health.ny.gov with a subject field as follows:

Subject: Unit ID: 3450449 Contract #: (to be determined)

Alternate Method: Mail vouchers to BSC at the following U.S. postal address:

**NYS Department of Health
Unit ID 3450449
c/o NYS OGS BSC Accounts Payable
Building 5, 5th Floor
1220 Washington Ave.
Albany, NY 12226-1900**

Payment for invoices and/or vouchers submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at epayments@osc.state.ny.us or by telephone at 518-474-6019. CONTRACTOR acknowledges that it will not receive payment on any invoices and/or vouchers submitted under this Contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9 must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at <http://www.osc.state.ny.us/epay>.

Completed W-9 forms should be submitted to the following address:

NYS Office of the State Comptroller
Bureau of Accounting Operations
Warrant & Payment Control Unit
110 State Street, 9th Floor
Albany, NY 12236

Payment of such invoices and/or vouchers by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be:

Monthly invoices based on deliverable completion, and hourly effort towards Special Studies.

5.5 Minority & Woman-Owned Business Enterprise Requirements

Pursuant to New York State Executive Law Article 15-A, the New York State Department of Health (“DOH”) recognizes its obligation to promote opportunities for maximum feasible participation of certified minority- and women-owned business enterprises and the employment of minority group members and women in the performance of DOH contracts.

In 2006, the State of New York commissioned a disparity study to evaluate whether minority and women-owned business enterprises had a full and fair opportunity to participate in state contracting. The findings of the study were published on April 29, 2010, under the title "The State of Minority and Women-Owned Business Enterprises: Evidence from New York" (“Disparity Study”). The report found evidence of statistically significant disparities between the level of participation of minority- and women-owned business enterprises in state procurement contracting versus the number of minority- and women-owned business enterprises that were ready, willing and able to participate in state procurements. As a result of these findings, the Disparity Study made recommendations concerning the implementation and operation of the statewide certified minority- and women-owned business enterprises program. The recommendations from the Disparity Study culminated in the enactment and the implementation of New York State Executive Law Article 15-A, which requires, among other things, that DOH establish goals for maximum feasible participation of New York State Certified minority- and women – owned business enterprises (“MWBE”) and the employment of minority groups members and women in the performance of New York State contracts.

Business Participation Opportunities for MWBEs

For purposes of this solicitation, DOH hereby establishes an overall goal of **30%** for MWBE participation, **15%** for Minority-Owned Business Enterprises (“MBE”) participation and **15%** for Women-Owned Business Enterprises (“WBE”) participation (based on the current availability of qualified MBEs and WBEs and outreach efforts to certified MWBE firms). A contractor (“Contractor”) on the subject contract (“Contract”) must document good faith efforts to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract and Contractor agrees that DOH may withhold payment pending receipt of the required MWBE documentation. For guidance on how DOH will determine “good faith efforts,” refer to 5 NYCRR §142.8.

The directory of New York State Certified MWBEs can be viewed at: <https://ny.newnycontracts.com>. The directory is found in the upper right-hand side of the webpage under “Search for Certified Firms” and accessed by clicking on the link entitled “MWBE Directory”. Engaging with firms found in the directory with like product(s) and/or service(s) is strongly encouraged and all communication efforts and responses should be well documented.

By submitting a bid, a bidder agrees to complete an MWBE Utilization Plan ([Attachment 5](#), Form #1) of this RFP. DOH will review the submitted MWBE Utilization Plan. If the plan is not accepted, DOH may issue a notice of deficiency. If a notice of deficiency is issued, Bidder agrees that it shall respond to the notice of deficiency within seven (7) business days of receipt. DOH may disqualify a Bidder as being non-responsive under the following circumstances:

- a) If a Bidder fails to submit a MWBE Utilization Plan;
- b) If a Bidder fails to submit a written remedy to a notice of deficiency;
- c) If a Bidder fails to submit a request for waiver (if applicable); or
- d) If DOH determines that the Bidder has failed to document good-faith efforts;

The Contractor will be required to attempt to utilize, in good faith, any MBE or WBE identified within its MWBE Utilization Plan, during the performance of the Contract. Requests for a partial or total waiver of established goal requirements made subsequent to Contract Award may be made at any time during the term of the Contract to DOH, but must be made no later than prior to the submission of a request for final payment on the Contract.

The Contractor will be required to submit a Contractor's Quarterly M/WBE Contractor Compliance & Payment Report to the DOH, by the 10th day following each end of quarter over the term of the Contract documenting the progress made toward achievement of the MWBE goals of the Contract.

If the Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in the Contract, such finding will constitute a breach of Contract and DOH may withhold payment from the Contractor as liquidated damages.

Such liquidated damages shall be calculated as an amount equaling the difference between: (1) all sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and (2) all sums actually paid to MWBEs for work performed or materials supplied under the Contract.

New York State certified Minority- and Women-Owned Businesses (M/WBE) may request that their firm's contact information be included on a list of M/WBE firms interested in serving as a subcontractor for this procurement. The listing will be publicly posted on the Department's website for reference by the bidding community. A firm requesting inclusion on this list should send contact information and a copy of its NYS M/WBE certification to oqps.asu@health.ny.gov before the Deadline for Questions as specified in [Section 1.0](#) (Calendar of Events). Nothing prohibits an M/WBE Vendor from proposing as a prime contractor.

Please Note: Failure to comply with the foregoing requirements may result in a finding of non-responsiveness, non-responsibility and/or a breach of the Contract, leading to the withholding of funds, suspension or termination of the Contract or such other actions or enforcement proceedings as allowed by the Contract.

5.6 Equal Employment Opportunity (EEO) Reporting

By submission of a bid in response to this solicitation, the Bidder agrees with all of the terms and conditions of [Attachment 8](#) Appendix A including Clause 12 - Equal Employment Opportunities for Minorities and Women. Additionally, the successful bidder will be required to certify they have an acceptable EEO (Equal Employment Opportunity) policy statement in accordance with Section III of Appendix M in [Attachment 8](#).

Further, pursuant to Article 15 of the Executive Law (the "Human Rights Law"), all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor and sub-contractors will not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

The Contractor is required to ensure that it and any subcontractors awarded a subcontract over \$25,000 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work"), except where the Work is for the beneficial use of the Contractor, undertake or continue programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status. For these purposes, equal opportunity shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, termination, and rates of pay or other forms of compensation. This requirement does not apply to: (i) work, goods, or services unrelated to the Contract; or (ii) employment outside New York State.

To ensure compliance with this Section, the Bidder should submit with the bid or proposal an Equal Employment Opportunity Staffing Plan ([Attachment 5](#), Form #4) identifying the anticipated work force to be utilized on the Contract. Additionally, the Bidder should submit a Minority and Women-Owned Business Enterprises and Equal Employment Opportunity Policy Statement ([Attachment 5](#), Form # 5), to DOH with their bid or proposal.

5.7 Sales and Compensating Use Tax Certification (Tax Law, § 5-a)

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded state contracts for commodities, services and technology valued at more than \$100,000 to certify to the Department of Tax and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to contracts where the total amount of such contractors' sales delivered into New York State are in excess of \$300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any affiliates and subcontractors whose sales delivered into New York State exceeded \$300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

This law imposes upon certain contractors the obligation to certify whether or not the contractor, its affiliates, and its subcontractors are required to register to collect state sales and compensating use tax and contractors must certify to DTF that each affiliate and subcontractor exceeding such sales threshold is registered with DTF to collect New York State and local sales and compensating use taxes. The law prohibits the State Comptroller, or other approving agencies, from approving a contract awarded to an offerer meeting the registration requirements but who is not so registered in accordance with the law.

The successful Bidder must file a properly completed Form ST-220-CA with the Department of Health and Form ST-220-TD with the DTF. These requirements must be met before a contract may take effect. Further information can be found at the New York State Department of Taxation and Finance's website, available through this link: <http://www.tax.ny.gov/pdf/publications/sales/pub223.pdf>.

Forms are available through these links:

- ST-220 CA: http://www.tax.ny.gov/pdf/current_forms/st/st220ca_fill_in.pdf
- ST-220 TD: http://www.tax.ny.gov/pdf/current_forms/st/st220td_fill_in.pdf

5.8 Contract Insurance Requirements

Prior to the start of work under this Contract, the CONTRACTOR shall procure, at its sole cost and expense, and shall maintain in force at all times during the term of this Contract, insurance of the types and in the amounts set forth in [Attachment 8](#), the New York State Department of Health Contract, Section IV. Contract Insurance Requirements as well as below.

5.9 Subcontracting

Bidder's may propose the use of a subcontractor. The Contractor shall obtain prior written approval from NYSDOH before entering into an agreement for services to be provided by a subcontractor. The Contractor is solely responsible for assuring that the requirements of the RFP are met. All subcontracts shall contain provisions specifying that the work performed by the subcontractor must be in accordance with the terms of the prime contract, and that the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in the agreement between the DOH and the Contractor. DOH reserves the right to request removal of any bidder's staff or subcontractor's staff if, in DOH's discretion, such staff is not performing in accordance with the Agreement. Subcontractors whose contracts are valued at or above \$100,000 will be required to submit the Vendor Responsibility Questionnaire upon selection of the prime contractor.

5.10 DOH's Reserved Rights

The Department of Health reserves the right to:

1. Reject any or all proposals received in response to the RFP;
2. Withdraw the RFP at any time, at the agency's sole discretion;
3. Make an award under the RFP in whole or in part;
4. Disqualify any bidder whose conduct and/or proposal fails to conform to the requirements of the RFP;
5. Seek clarifications and revisions of proposals;
6. Use proposal information obtained through site visits, management interviews and the state's investigation of a bidder's qualifications, experience, ability or financial standing, and any material or information submitted by the bidder in response to the agency's request for clarifying information in the course of evaluation and/or selection under the RFP;

7. Prior to the bid opening, amend the RFP specifications to correct errors or oversights, or to supply additional information, as it becomes available;
8. Prior to the bid opening, direct bidders to submit proposal modifications addressing subsequent RFP amendments;
9. Change any of the scheduled dates;
10. Eliminate any mandatory, non-material specifications that cannot be complied with by all of the prospective bidders;
11. Waive any requirements that are not material;
12. Negotiate with the successful bidder within the scope of the RFP in the best interests of the state;
13. Conduct contract negotiations with the next responsible bidder, should the Department be unsuccessful in negotiating with the selected bidder;
14. Utilize any and all ideas submitted in the proposals received;
15. Every offer shall be firm and not revocable for a period of three hundred and sixty-five days from the bid opening, to the extent not inconsistent with section 2-205 of the uniform commercial code. Subsequent to such three hundred and sixty- five days, any offer is subject to withdrawal communicated in a writing signed by the offerer; and,
16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an offerer's proposal and/or to determine an offerer's compliance with the requirements of the solicitation.

5.11 Freedom of Information Law ("FOIL")

All proposals may be disclosed or used by DOH to the extent permitted by law. DOH may disclose a proposal to any person for the purpose of assisting in evaluating the proposal or for any other lawful purpose. All proposals will become State agency records, which will be available to the public in accordance with the Freedom of Information Law. **Any portion of the proposal that a Bidder believes constitutes proprietary information entitled to confidential handling, as an exception to the Freedom of Information Law, must be clearly and specifically designated in the proposal as directed in [Section 6.1 \(B\)](#) of the RFP.** If DOH agrees with the proprietary claim, the designated portion of the proposal will be withheld from public disclosure. Blanket assertions of proprietary material will not be accepted and failure to specifically designate proprietary material may be deemed a waiver of any right to confidential handling of such material.

5.12 Lobbying

Chapter 1 of the Laws of 2005, as amended by Chapter 596 of the Laws of 2005, made significant changes as it pertains to development of procurement contracts with governmental entities. The changes included:

- a) made the lobbying law applicable to attempts to influence procurement contracts once the procurement process has been commenced by a state agency, unified court system, state legislature, public authority, certain industrial development agencies and local benefit corporations;
- b) required the above-mentioned⁷ governmental entities to record all contacts made by lobbyists and contractors about a governmental procurement so that the public knows who is contacting governmental entities about procurements;
- c) required governmental entities to designate persons who generally may be the only staff contacted relative to the governmental procurement by that entity in a restricted period;
- d) authorized the New York State Commission on Public Integrity, (now New York State Joint Commission on Public Ethics), to impose fines and penalties against persons/organizations engaging in impermissible contacts about a governmental procurement and provides for the debarment of repeat violators;
- e) directed the Office of General Services to disclose and maintain a list of non-responsible bidders pursuant to this new law and those who have been debarred and publish such list on its website;

- f) required the timely disclosure of accurate and complete information from offerers with respect to determinations of non-responsibility and debarment; (Bidders responding to this RFP should submit a completed and signed [Attachment 1](#), "Prior Non-Responsibility Determination".)
- g) increased the monetary threshold which triggers a lobbyist's obligations under the Lobbying Act from \$2,000 to \$5,000; and
- h) established the Advisory Council on Procurement Lobbying.

Subsequently, Chapter 14 of the Laws of 2007 amended the Lobbying Act of the Legislative Law, particularly as it related to specific aspects of procurements as follows: (i) prohibiting lobbyists from entering into retainer agreements on the outcome of government grant making or other agreement involving public funding; and (ii) reporting lobbying efforts for grants, loans and other disbursements of public funds over \$15,000.

The most notable, however, was the increased penalties provided under Section 20 of Chapter 14 of the Laws of 2007, which replaced old penalty provisions and the addition of a suspension option for lobbyists engaged in repeated violations. Further amendments to the Lobbying Act were made in Chapter 4 of the Laws of 2010.

Questions regarding the registration and operation of the Lobbying Act should be directed to the New York State Joint Commission on Public Ethics.

5.13 State Finance Law Consultant Disclosure Provisions

In accordance with New York State Finance Law Section 163(4)(g), State agencies must require all contractors, including subcontractors, that provide consulting services for State purposes pursuant to a contract to submit an annual employment report for each such contract.

The successful bidder for procurements involving consultant services must complete a "State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term" in order to be eligible for a contract.

The successful bidder must also agree to complete a "State Consultant Services Form B, Contractor's Annual Employment Report" for each state fiscal year included in the resulting contract. This report must be submitted annually to the Department of Health, the Office of the State Comptroller, and Department of Civil Service.

State Consultant Services Form A: Contractor's Planned Employment and Form B: Contractor's Annual Employment Report may be accessed electronically at: <http://www.osc.state.ny.us/agencies/forms/ac3271s.doc> and <http://www.osc.state.ny.us/agencies/forms/ac3272s.doc>.

5.14 Debriefing

Once an award has been made, bidders may request a debriefing of their proposal. Please note the debriefing will be limited only to the strengths and weaknesses of the bidder's proposal, and will not include any discussion of other proposals. Requests must be received no later than fifteen (15) calendar days from date of award or non-award announcement.

5.15 Protest Procedures

In the event unsuccessful bidders wish to protest the award resulting from this RFP, bidders should follow the protest procedures established by the Office of the State Comptroller (OSC). These procedures can be found in Chapter XI Section 17 of the Guide to Financial Operations (GFO). Available on-line at: <http://www.osc.state.ny.us/agencies/guide/MyWebHelp/>

5.16 Iran Divestment Act

By submitting a bid in response to this solicitation or by assuming the responsibility of a Contract awarded hereunder, Bidder/Contractor (or any assignee) certifies that it is not on the “Entities Determined To Be Non-Responsive Bidders/Offerers Pursuant to The New York State Iran Divestment Act of 2012” list (“Prohibited Entities List”) posted on the OGS website (currently found at this address: <http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf>) and further certifies that it will not utilize on such Contract any subcontractor that is identified on the Prohibited Entities List. Additionally, Bidder/Contractor is advised that should it seek to renew or extend a Contract awarded in response to the solicitation, it must provide the same certification at the time the Contract is renewed or extended.

During the term of the Contract, should DOH receive information that a person (as defined in State Finance Law §165-a) is in violation of the above-referenced certifications, DOH will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then DOH shall take such action as may be appropriate and provided for by law, rule, or contract, including, but not limited to, seeking compliance, recovering damages, or declaring the Contractor in default. DOH reserves the right to reject any bid, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

5.17 Piggybacking

New York State Finance Law section 163(10)(e) (see also <http://www.ogs.ny.gov/purchase/snt/sflxi.asp>) allows the Commissioner of the NYS Office of General Services to consent to the use of this contract by other New York State Agencies, and other authorized purchasers, subject to conditions and the Contractor’s consent.

5.18 Encouraging Use of New York Businesses in Contract Performance

Public procurements can drive and improve the State’s economic engine through promotion of the use of New York businesses by its contractors. New York State businesses have a substantial presence in State contracts and strongly contribute to the economies of the state and the nation. In recognition of their economic activity and leadership in doing business in New York State, bidders/proposers for this contract for commodities, services or technology are strongly encouraged and expected to consider New York State businesses in the fulfillment of the requirements of the contract. Such partnering may be as subcontractors, suppliers, protégés or other supporting roles. All bidders should complete [Attachment 6](#), Encouraging Use of New York Businesses in Contract Performance, to indicate their intent to use/not use New York Businesses in the performance of this contract.

5.19 Diversity Practices Questionnaire

Diversity practices are the efforts of contractors to include New York State-certified Minority and Women-owned Business Enterprises (“MWBES”) in their business practices. Diversity practices may include past, present, or future actions and policies, and include activities of contractors on contracts with private entities and governmental units other than the State of New York. Assessing the diversity practices of contractors enables contractors to engage in meaningful, capacity-building collaborations with MWBEs.

5.20 Participation Opportunities for NYS Certified Service-Disabled Veteran-Owned Businesses

Article 17-B of the New York State Executive Law provides for more meaningful participation in public procurement by certified Service-Disabled Veteran-Owned Businesses (“SDVOBs”), thereby further integrating such businesses into New York State’s economy. DOH recognizes the need to promote the employment of service-disabled veterans and to ensure that certified service-disabled veteran-owned businesses have opportunities for maximum feasible participation in the performance of DOH contracts.

In recognition of the service and sacrifices made by service-disabled veterans and in recognition of their economic activity in doing business in New York State, Bidders/Contractors are strongly encouraged and expected to consider SDVOBs in the fulfillment of the requirements of the Contract. Such participation may be as subcontractors or suppliers, as protégés, or in other partnering or supporting roles.

For purposes of this procurement, DOH conducted a comprehensive search and determined that the Contract does not offer sufficient opportunities to set specific goals for participation by SDVOBs as subcontractors, service providers, and suppliers to Contractor. Nevertheless, Bidder/Contractor is encouraged to make good faith efforts to promote and assist in the participation of SDVOBs on the Contract for the provision of services and materials. The directory of New York State Certified SDVOBs can be viewed at: <https://ogs.ny.gov/veterans/>

Bidders are encouraged to contact the Office of General Services' Division of Service-Disabled Veteran's Business Development at 518-474-2015 or VeteransDevelopment@ogs.ny.gov to discuss methods of maximizing participation by SDVOBs on the Contract.

5.21 Intellectual Property

Any work product created pursuant to this agreement and any subcontract shall become the sole and exclusive property of the New York State Department of Health, which shall have all rights of ownership and authorship in such work product.

5.22 Vendor Assurance of No Conflict of Interest or Detrimental Effect

All bidders responding to this solicitation should submit [Attachment 4](#) to attest that their performance of the services outlined in this RFP does not create a conflict of interest and that the bidder will not act in any manner that is detrimental to any other State project on which they are rendering services.

5.23 Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination

The New York State Human Rights Law, Article 15 of the Executive Law, prohibits discrimination and harassment based on age, race, creed, color, national origin, sex, pregnancy or pregnancy-related conditions, sexual orientation, gender identity, disability, marital status, familial status, domestic violence victim status, prior arrest or conviction record, military status or predisposing genetic characteristics. In accordance with Executive Order No. 177, the Offeror certifies that they do not have institutional policies or practices that fail to address those protected status under the Human Rights Law.

6.0 PROPOSAL CONTENT

The following includes the format and information to be provided by each Bidder. Bidders responding to this RFP must satisfy all requirements stated in this RFP. All Bidders are requested to submit complete Administrative and Technical Proposals, and are required to submit a complete Cost Proposal. A proposal that is incomplete in any material respect may be rejected.

To expedite review of the proposals, Bidders are requested to submit proposals in separate Administrative, Technical, and Cost packages inclusive of all materials as summarized in Attachment A, Proposal Documents. This separation of information will facilitate the review of the material requested. No information beyond that specifically requested is required, and Bidders are requested to keep their submissions to the shortest length consistent with making a complete presentation of qualifications. Evaluations of the Administrative, Technical, and Cost Proposals received in response to this RFP will be conducted separately. Bidders are therefore cautioned not to include any Cost Proposal information in the Technical Proposal documents.

DOH will not be responsible for expenses incurred in preparing and submitting the Administrative, Technical, or Cost Proposals.

6.1 Administrative Proposal

The Administrative Proposal should contain all items listed below. A proposal that is incomplete in any material respect may be eliminated from consideration. The information requested should be provided in the prescribed format. Responses that do not follow the prescribed format may be eliminated from consideration. All responses to the RFP may be subject to verification for accuracy. Please provide the forms in the same order in which they are requested.

A. Bidder's Disclosure of Prior Non-Responsibility Determinations

Submit a completed and signed [Attachment 1](#), "Prior Non-Responsibility Determination."

B. Freedom of Information Law – Proposal Redactions

Bidders must clearly and specifically identify any portion of the proposal that a Bidder believes constitutes proprietary information entitled to confidential handling as an exception to the Freedom of Information Law. See [Section 5.11](#), (Freedom of Information Law)

C. Vendor Responsibility Questionnaire

Complete, certify, and file a New York State Vendor Responsibility Questionnaire. DOH recommends that vendors file the required Vendor Responsibility Questionnaire online via the New York State VendRep System. To enroll in and use the New York State VendRep System, see the VendRep System Instructions at <http://www.osc.state.ny.us/vendrep/index.htm> or go directly to the VendRep System online at <https://portal.osc.state.ny.us>.

Vendors must provide their New York State Vendor Identification Number when enrolling. To request assignment of a Vendor ID or for VendRep System assistance, contact the OSC Help Desk at 866-370-4672 or 518-408-4672 or by email at ciohelpdesk@osc.state.ny.us.

Vendors opting to complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website, www.osc.state.ny.us/vendrep, or may contact the Office of the State Comptroller's Help Desk for a copy of the paper form. Bidders should complete and submit the Vendor Responsibility Attestation, [Attachment 3](#).

D. Vendors Assurance of No Conflict of Interest or Detrimental Effect

Submit [Attachment 4](#), Vendor's Assurance of No Conflict of Interest or Detrimental Effect, which includes information regarding the Bidder, members, shareholders, parents, affiliates or subcontractors. [Attachment 4](#) must be signed by an individual authorized to bind the Bidder contractually.

E. M/WBE Forms

Submit completed Form #1 and/or Form #2, Form #4 and Form #5 as directed in [Attachment 5](#), "Guide to New York State DOH M/WBE RFP Required Forms."

F. Encouraging Use of New York Businesses in Contract Performance

Submit [Attachment 6](#), "Encouraging Use of New York State Businesses" in Contract Performance to indicate which New York Businesses you will use in the performance of the contract.

G. Bidder's Certified Statements

Submit [Attachment 7](#), "Bidder's Certified Statements", which includes information regarding the Bidder. Attachment A must be signed by an individual authorized to bind the Bidder contractually. Please indicate the title or position that the signer holds with the Bidder. DOH reserves the right to reject a proposal that contains an incomplete or unsigned [Attachment 7](#) or no [Attachment 7](#).

H. References

Provide references using [Attachment 9](#). (References) for three *state agencies to which you provided External Quality Review services and/or clients to which you provided program evaluation services.*) Provide firm names, addresses, contact names, telephone numbers, and email addresses.

I. Diversity Practices Questionnaire

The Department has determined, pursuant to New York State Executive Law Article 15-A, that the assessment of the diversity practices of respondents of this procurement is practical, feasible, and appropriate. Accordingly, respondents to this procurement should include as part of their response to this procurement, [Attachment 10](#) "Diversity Practices Questionnaire". Responses will be formally evaluated and scored.

J. Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination

Submit [Attachment 11](#) certifying that it does not have institutional policies or practices that fail to address the harassment and discrimination of individuals on the basis of their age, race, creed, color, national origin, sex, sexual orientation, gender identity, disability, marital status, military status, or other protected status under the Human Rights Law.

K. Transmittal Form

The transmittal form should be submitted by the bidder proposing to be the prime contractor and must be signed by an individual legally authorized to represent the bidder organization. It will be evaluated as part of the Compliance Evaluation screening. Failure to include the Transmittal Form may result in disqualification of the bidder's proposal. The transmittal form is provided in Attachment D and the bidder must include the following:

- a) Bidder's complete name and address
- b) Legal structure of the entity submitting the offer
- c) NYS Vendor ID number
- d) Name, mailing address, email address, fax number and telephone number for both the authorized signatory and the person the Department should contact regarding the proposal
- e) Statement that the bidder is designated by the Center for Medicaid and Medicare Services (CMS) as a Medicare Quality Improvement Organization (QIO) or on the list of QIO-like organizations as of August 19, 2021.
- f) Statement that the bidder has either:
 - (1) Included a disclosure of any potential conflict of interest, including but not limited to: all business, financial or beneficial relationships, or interests in any affiliation or contractual relationship with, any health care provider, health insurer, its affiliates, its subsidiaries, or its parent. In cases where such a relationship(s) and/or interest(s) exists, the bidder must describe how an actual or potential conflict of interest and/or disclosure of confidential information relating to an award under this contract will be avoided, and the bidder guarantees knowledge and full compliance with the NYS Public Officers' Law, as amended, including but not limited to Sections 73 and 74, with regard to ethical standards applicable to State employees

OR

- (2) Has no conflict(s) of interest
- g) Statement that the bidder does/does not propose to utilize the services of a subcontractor(s). If the proposal includes the services of a subcontractor(s), the bidder should include, in an appendix to the Transmittal Form, a subcontractor summary for each subcontractor, including:
 - (1) Complete name of the subcontractor

- (2) Complete address of the subcontractor
 - (3) A general description of the type and scope of work the subcontractor will be performing
 - (4) Percentage of work the subcontractor will be providing
 - (5) A statement confirming that the subcontractor is prepared, if requested by the Department, to present evidence of legal authority to do business in NYS, subject to the sole satisfaction of the Department
- h) Bidder attestations:
By signing the Transmittal Form, bidder certifies that it:
- (1) Accepts the contract terms and conditions contained in this RFP including any exhibits and attachments
 - (2) Has received and acknowledged all Department amendments to the RFP, as may be amended
 - (3) Is prepared, if requested by the Department, to present evidence of legal authority to do business in NYS, subject to the sole satisfaction of the Department
 - (4) (i) Does not qualify its proposal, or include any exceptions from the RFP and (ii) acknowledges that should any alternative proposals or extraneous terms be submitted with the proposal, such alternate proposals or extraneous terms will not be evaluated by the Department; and
 - (5) Certifies the proposal will remain valid for a minimum of 365 calendar days from the closing date for submission of proposals.

6.2 Technical Proposal

The purpose of the Technical Proposal is to demonstrate the qualifications, competence, and capacity of the Bidder to perform the services contained in this RFP. The Technical Proposal should demonstrate the qualifications of the Bidder and the staff to be assigned to provide services related to the services included in this RFP.

A Technical Proposal that is incomplete in any material respect may be eliminated from consideration. The following outlines the information requested to be provided by Bidders. The information requested should be provided in the prescribed format. Responses that do not follow the prescribed format may be eliminated from consideration. All responses to the RFP may be subject to verification for accuracy.

While additional data may be presented, the following should be included. Please provide the information in the same order in which it is requested. Your proposal should contain sufficient information to assure DOH of its accuracy. Failure to follow these instructions may result in disqualification.

Pricing information contained in the Cost Proposal cannot be included in the Technical Proposal documents.

A. Title Page

Submit a Title Page providing the RFP subject and number; the Bidder's name and address, the name, address, telephone number, and email address of the Bidder's contact person; and the date of the Proposal.

B. Table of Contents

The Table of Contents should clearly identify all material (by section and page number) included in the proposal.

C. Documentation of Bidder's Eligibility Responsive to Section 3.0 of RFP

Bidders must be able to meet all the requirements stated in Section 3.0 of the RFP. The bidder must submit documentation that provides sufficient evidence of meeting the criterion. This documentation may be in any format needed to demonstrate how they meet the minimum qualifications to propose.

- At the time of RFP issuance, the Bidder must be an organization designated by CMS as a Medicare QIO or QIO-like organization;
- The Bidder must not be a State health care facility; an association of health care facilities conducting business in the State, or an affiliate of a State health care facility; and,
- At the time of bid, the Bidder and any proposed subcontractors must attest in writing that it meets the conditions for independence as defined in federal regulation at 42 CFR 438.354(c).

For the purposes of this RFP, a prime contractor is defined as one who has the contract with the owner of a project or job and has full responsibility for its completion. A prime contractor undertakes to perform a complete contract and may employ (and manage) one (1) or more subcontractors to carry out specific parts of the contract.

If the proposal includes the services of a subcontractor(s), the bidder should include, in an appendix to the Transmittal Form, a subcontractor summary for each subcontractor, including:

- Complete name of the subcontractor
- Complete address of the subcontractor
- A general description of the type and scope of work the subcontractor will be performing
- Percentage of work the subcontractor will be providing
- A statement confirming that the subcontractor is prepared, if requested by the State DOH, to present evidence of legal authority to do business in the State, subject to the sole satisfaction of the State DOH

Failure to meet these Minimum Qualifications will result in a proposal being found non-responsive and eliminated from consideration.

D. Technical Proposal Narrative

The technical proposal should provide satisfactory evidence of the Bidder's ability to meet, and expressly respond to, each element listed below.

Elements of the technical proposal are as follows:

D1. Corporate Experience

The proposal should describe the Bidder's experience in conducting the activities set forth in Section 4, Scope of Work, to demonstrate the organization's ability to accomplish the goals and objectives of the RFP. Any applicable experience can be included, but Bidders should include descriptions of relevant activities within the last five (5) years. The Bidder is required to provide a list of contracts within the last two (2) years from the date of the release of this RFP, which relate to the activities in this RFP and include contact person(s) names and phone numbers regarding these contracts, dates and scope of efforts.

D2. Staffing

The Bidder's proposed approach should include:

- a. A plan for staffing that adequately meets the details described in **Section 4.3 4.2, Staffing**. This plan should include detailed information regarding staffing numbers and teams to accomplish the projected workload. The proposal should include a proposed organizational chart.
- b. A job description for each position proposed to meet the project activities and deliverables, including supervisory staff to manage the contract deliverables. Position descriptions should not include salary level or other employee cost information. Describe the proposed duties and tasks for each position.

- c. A description of how internal management will be conducted for this contract. In addition to general hierarchical management of organizational resources, plans for developing services and products, and timely delivery of products and services, management oversight also includes internal controls that assure effective communication and coordination of the contract scope of work including integrity of all products throughout the course of the contract period; and, assuring professionally prepared, clear, accurate, and meaningful written products targeted to the DOH's intended audience(s);
- d. Qualifications of staff responsible for conducting all aspects of the contract, including but not limited to clinical staff, staff with experience in primary care and staff who will conduct research and data analysis, including educational background, specialized training, professional experience/knowledge, and special qualifications. At minimum, qualifications of the staff referenced in the RFP Scope of Work should be described.
- e. How the personnel will be utilized for the project and the percentage of time they will devote to this contract.
- f. An approach for recruitment.
- g. A plan for training physician and non-physician reviewer staff according to the details described in **Section 4.3 4.2, Staffing.**
- h. A plan for credentialing physician and non-physician review staff, including all medical record review staff.
- i. Description of the experience and special qualifications of consultants to be involved in the contract as well as those of any proposed subcontractor (s).
- j. Description of where operations will be located, how and from where staff will be deployed to conduct statewide activities, and locations where the Bidder will carry out the activities and responsibilities associated with implementing this contract.

NOTE: Resumes are not required and will not be evaluated.

D3. Start-up Plan and Schedule of Deliverables

A detailed three (3)-month start-up plan is required as part of the Technical Proposal. It should include all activities the Contractor will undertake to implement the review system within 90 days of OSC contract approval. This includes notifying providers, hiring staff, and establishing an office in the State, where necessary.

As part of the Proposed Approach below, the Contractor should also provide an annual and startup work plan which will be incorporated into a five (5) year "schedule of deliverables."

D4. Proposed Approach

The Bidder's proposed approach should address and respond to each of the components described in **Section 4, Scope of Work**, following the requirements listed below.

The proposed approach should explain in detail the Bidder's specific plan for managing and performing the required tasks and activities for each of the project areas described therein. As appropriate, the proposed approach should thoroughly describe how the Bidder's past experiences and lessons learned will be applied to the projects outlined in this RFP.

Bidders proposing to procure the services of subcontractors should also demonstrate the experience and expertise of each entity and describe how work will be coordinated and managed by the Bidder. A lack of detail in responses will not be evaluated favorably, such as proposals that merely offer to conduct the work required under this RFP in accordance with the Scope of Work.

The proposed approach will be evaluated to determine the appropriateness and reasonableness of the Bidder's plan for meeting the goals and responsibilities described in the RFP. While sufficient details are necessary to summarize the Bidder's ability to perform the services contained in this RFP, the proposed approach should be clear and straightforward; excessive pages of information will not be evaluated favorably. The proposed approach will become the successful Bidder's work plan upon implementation of the contract. If necessary, the State DOH may request minor modifications to the Contractor's work plans prior to the start of and/or during the contract to ensure that all project requirements are being fully met.

Required components for each Bidder's proposed approach are listed below under the applicable program or topic area. The proposed approach should be structured and numbered accordingly.

1) External Quality Review Activities

For each External Quality Review activity described, the Bidder's proposed approach should include a comprehensive external quality review work plan(s) and timeline(s) that clearly describe and illustrate the duration required to complete each activity; preliminary and start-up work plans; a plan for collecting and maintaining data; and a plan for checking and analyzing results.

1. For validation of PIPs, the Bidder should describe how they propose to:
 - a. Verify that the PIP used sound methodology in its design, implementation, analysis and reporting.
 - b. Provide written feedback to each MCO regarding their study methodology, collect updated methodologies from MCOs and obtain State DOH approval.
 - c. Conduct enhanced validation to coordinate and facilitate progress.
 - d. Coordinate collaboration among the plans.
 - e. Perform overall validation and reporting of PIP results.
 - f. Verify the PIP findings.
 - g. Collect and review Interim and Final Reports from MCOs, provide feedback and submit the Reports to the State DOH.
 - h. Prepare an annual summary compendium report and conduct meetings to share the results and promising practices.
 - i. Report to the State DOH its findings in the EQR Technical Report.

2. For validation of performance measures, the Bidder should describe how they propose to:
 - a. Validate the specified performance measures.
 - b. Assess whether the performance measures calculated by the MCO are accurate.
 - c. Conduct pre-onsite visit activities.
 - d. Conduct onsite visit activities.
 - e. Conduct post-onsite visit activities.
 - f. For validation of MCO quality performance measure data:
 - i. Develop a submission platform allowing secure file transfer from plans to the Contractor for all required QARR files.
 - ii. Develop a data submission tool.
 - iii. Provide external oversight of the QARR submission process.
 - iv. Ensure the accuracy of the data and submit a summary report of findings.
 - v. Provide annual technical assistance and training to MCOs.
 - vi. Assist the State DOH with QARR measure specifications, review and validate source code, develop and host an annual webinar for MCO staff, provide training and technical assistance to MCOs when new measures are incorporated and collect data from MCOs and provide these to the State DOH.
 - vii. Monitor that all required files are submitted by the deadline, perform a preliminary data check to identify any quality issues, and document extent of correctness in a preliminary findings report to the State DOH.
 - viii. Compile and validate files into large datasets used by the State DOH annually.
 - ix. Review NCQA-certified auditors' Compliance Audit Final Report designations and findings to further assess the accuracy of measures and the extent to which measures follow specifications and reporting requirements.
 - x. Provide ongoing technical assistance to MCOs, serve as liaison between MCOs, NCQA subcontractors and the State DOH, and participate in meetings with key MCO personnel to assist in implementing corrective actions.
 - g. For validation of functional assessment data:
 - i. Perform timely validations of data to ensure integrity for program functions and submit draft and final reports to the State DOH.
 - ii. Prepare and submit a data validation proposal to the State DOH for approval with consideration of possible amendments needed for newer plans and refining the proposal based on State DOH feedback.

- iii. Prepare and send written correspondence to community-based providers and schedule visits with them or request medical records submission by the plans.
 - iv. Conduct the data validation after receiving the records, submit a draft report to the State DOH, send the draft report to the providers for response, update the report, submit the report to the State DOH for approval and send the final validation reports to the plans.
- 3. For review of compliance with Medicaid and CHIP managed care regulations, the Bidder should describe how they propose to:
 - a. Establish compliance thresholds.
 - b. Perform the preliminary review (pre-onsite visit).
 - c. Conduct the MCO onsite visit.
 - d. Compile and analyze findings (post-onsite visit).
 - e. Conduct surveys to determine adequate access and availability of care to providers, responsiveness of MCO member services departments and confirm MCO provider network directory accuracy.
 - f. Continue the surveys to annually review MCP compliance with federal standards.
 - g. Work with the State DOH to identify and define standards for compliance; compile results from State DOH audits, surveys of access and availability, member services surveys and provider directory evaluations for each MCO; maintain consistent communication with each MCP; determine if compliance with each federal standard was met for each MCO; analyze findings; and prepare a narrative that outlines compliance determinations.
 - h. Report results to the State DOH.
 - i. For validation of Medicaid MCO provider directories:
 - i. Conduct a validation of Medicaid MCO web-based Provider Directories twice a year.
 - ii. Place phone calls to provider offices to obtain confirmation of PCP participation in MCO network, practicing specialty, Medicaid panel status, physical location and telephone number; and report discrepancies to the MCO for correction.
 - iii. Perform the validation, describe the methodology and develop a protocol for survey administration for State DOH approval.
 - iv. Generate a random sample of providers and conduct the survey.
 - v. Produce a summary report of survey findings for each MCO, submit the report to the State DOH and provide revisions as needed.
 - j. For the access and availability survey:
 - i. Develop a protocol for conducting the surveys and obtain State DOH approval.
 - ii. Produce an annual summary report of survey findings for each MCO, submit the report to the State DOH for approval and provide revisions as needed.
 - iii. For the primary care/OB-GYN survey:
 - 1. Generate a random sample of providers using each MCP's web-based Provider Directory and remove non-participating providers.
 - 2. Place phone calls according to the four (4) scenarios in the RFP scope of work, and use the template provided in the RFP to track results.
 - 3. Complete the survey and track the success rate using the template and include plans that did not meet the threshold criteria in the next round of the access and availability survey.
 - iv. For the behavioral health program survey:
 - 1. Generate a random sample of providers.
 - 2. Place phone calls according to the two (2) scenarios in the RFP scope of work, track the success rate using the template and include plans that did not meet the threshold in the next round of the access and availability survey.
 - v. For the plan member services survey:
 - 1. Conduct initial phone calls and submit survey outcome reports to the State DOH.
 - 2. Conduct follow up phone calls testing non-compliant questions/inquiries and submit reports to the State DOH.
 - vi. For the high-volume enrollee to provider ratio survey:
 - 1. Develop a data collection tool for State DOH approval.

2. Conduct the annual survey, calculate appointment availability rates, and submit a report to the State DOH, submit draft results notification letters for each MCO to the State DOH, revise the letters as needed, and send the letters and reports to the MCOs.
4. For validation of network adequacy:
 - a. For validation of provider network data:
 - i. Assess the adequacy of the network offered by each plan for each line of business.
 - ii. Develop and maintain templates outlining adequacy standards for each line of business.
 - iii. Conduct the measurements specified in the RFP scope of work using data submitted by health plans to the State DOH and other existing market data facility lists provided by OMH and OASAS.
 - iv. Use the measurements to determine whether or not each standard has been met by each MCO network within each geographic region.
 - v. Categorize unmet standards into deficiency types by plan and by product.
 - vi. Maintain historical adequacy reviews and trend data over time, combined into a dataset for sharing with the State DOH on a quarterly basis after data are received from the plans.
 - vii. Create and maintain metadata that describes how the analyses are performed.
 - viii. Provide technical assistance to the MCOs.
 5. For validation of encounter data reported by the Medicaid and CHIP MCP:
 - a. Review State requirements.
 - b. Design an annual encounter data validation strategy.
 - c. Prepare a validation analysis plan for State DOH approval; evaluate the validity and completeness of data; assess new MCOs readiness to submit encounter data including developing and hosting a webinar to train new plans; analyze and provide technical assistance to plans regarding their use of vendors in data collection; continue evaluation of provider-sponsored information system capability; and assist plans in data and process quality improvement.
 - d. Review medical records.
 - e. Recommend the selection of plans and/or data items for validation.
 - f. Prepare a draft and final validation report for State DOH approval and submit the final report to the plans with a cover letter.
 6. For administration of quality of care surveys:
 - a. Identify the survey purpose, objectives and audience.
 - b. Develop a work plan.
 - c. Design and conduct valid and reliable surveys for enrollees and providers.
 - d. Develop additional non-CAHPS® surveys, including the methodology, protocol, sampling, data collection and analysis, administration method, and tools.
 - e. Develop the sampling plan.
 - f. Develop a strategy to maximize the response.
 - g. Develop a quality assurance plan.
 - h. Implement the survey according to the work plan.
 - i. Prepare and analyze survey data and present the results in a final report to the State DOH.
 - j. For the CAHPS® survey:
 - i. Develop a workplan for State DOH approval.
 - ii. Conduct the CAHPS® surveys.
 - iii. Provide the State DOH with a final report, the data generated from the responses and prepare and submit the survey tools and data to AHRQ.
 - k. For the non- CAHPS® survey:
 - i. Develop a workplan for State DOH approval.
 - ii. Conduct the surveys.
 - iii. Provide the State DOH with a final report, member-level data set of responses and participate in an annual conference call or on-site meeting with MCOs to discuss findings and improvement strategies.
 7. For calculation of additional performance measures:
 - a. Prepare for measurement.

- b. Create the measures.
 - c. Identify priority areas or gaps where measures are needed.
 - d. Refine and finalize new measure topics.
 - e. Review existing measures for comparison to candidate measures.
 - f. Review existing studies that can be used as the evidence base for new measures.
 - g. Provide a summary report to the State DOH.
 - h. Compile scientific evidence using the National Quality Forum evidence criterion and complete a measure justification form.
 - i. Convene a panel to review the measure concept, proposed measure, evaluation of existing measures and scientific evidence; assist with meeting logistics and develop relevant materials for review; and provide a summary report to the State DOH.
 - j. Develop technical specifications for data collection and calculation of any panel-recommended measures.
 - k. Construct a comprehensive data protocol and develop source code for any administrative measures, and develop a flowchart documenting key decision points.
 - l. Develop a workplan for testing the measures for State DOH approval, implement the workplan, analyze test results and refine measure specifications as needed, and report the results to the State DOH.
 - m. Prepare documentation to solicit public comment on the measures, respond to the comments and submit a report to the State DOH, and facilitate any revisions from the State DOH to refine the measures.
 - n. Provide the State DOH with analysis plans, report formats, and draft reports for approval, and analyze and present the results to the State DOH and its stakeholders.
 - o. Review measure performance on an ongoing basis, evaluate the usefulness and provide recommendations on continuation, refinement or retirement of measures to the State DOH, and document the continuing evaluation/maintenance of measures in an annual report to the State DOH.
8. For conducting focused studies of health care quality:
- a. Work with the State DOH to identify the topic and scope of the study.
 - b. Develop sound methodology.
 - c. Review the design and implementation using documents provided by the MCO.
 - d. Develop a study design for State DOH approval according to the specifications in the RFP scope of work.
 - e. Train reviewers on the data collection tools, submit requests to MCOs to provide data or medical records, and collect the data and input the data into the tool.
 - f. Provide findings in a technical report, prepare a data analysis plan outlining the report format for State DOH approval, and analyze the data.
 - g. Present the findings in a meeting to MCO medical and quality directors and send the final report to the MCOs.
 - h. Report on the findings in the EQR Technical Report.
9. For the EQR Technical Report:
- a. Produce the report in a manner and template approved by the State DOH.
 - b. Include information specified in the RFP scope of work.
 - c. Address EQR activities for all Medicaid MCOs.
 - d. Include individual plan reports and a statewide summary with State-level recommendations for performance improvement.
 - e. Calculate trends, ratios or other descriptive indicators.
 - f. Include findings from MCO compliance with State standards and any additional data and information requested by the State DOH.
 - g. Include statewide benchmarks and trends over time.
 - h. Include a section that addresses the State's Quality Strategy and determine whether any updates are necessary based on the results of the EQR.
 - i. Submit an outline of the proposed format to the State DOH and submit the draft and final reports according to the RFP scope of work.
10. For the focus groups:
- a. Develop recruitment criteria.
 - b. Manage the group.

- c. Record the interviews.
- d. Produce transcripts.
- e. Analyze the transcripts.
- f. Provide a report to the State DOH.

2) Office Based Surgery

Describe the Bidder's approach to the following:

1. Assist in identifying potential risks and/or trends in standards of care that indicate areas needing improvement in the quality of care provided in the OBS setting.
2. Conduct quality of care reviews using the OBS Dashboard/AER Database.
3. Use the OBS program's electronic applications and forms to review the AER(s), associated medical records, documentation of quality of care review findings with summarization, recommendations for referrals and quality of care determination.
4. Train Contractor staff to understand the State DOH's review system; how to conduct medical record reviews and abstract information necessary to make a case determination from the medical record regarding the quality of care provided; how to incorporate guidelines and standard practices into review activities; and how to perform internal quality control monitoring and training to ensure accuracy and consistency in conducting a quality of care AER review.
5. Notify the OBS program of the identified need for a specialist consult, obtain approval, prepare and initiate the request, receive the consultant's documentation and update the review documentation to include the consultant's summary and findings.
6. For closed cases, select and contact the physician specialist to complete the consult, prepare the consult request, receive and update documentation of the specialist's summary/findings, and return the completed findings/recommendations and/or indication for referral(s) to the OBS program.
7. Participate in monthly meetings and provide a monthly progress report to the State DOH including the information detailed in the RFP scope of work, and participate in quality improvement meetings to review findings and report on core service activities.
8. Data collection, database edits, updates, maintenance and monthly SAS export to support the OBS program's quality of care reviews and quality improvement initiatives.
9. Maintain existing applications for the OBS program as described in the RFP scope of work.
10. Conduct a full assessment of the business, software, and hardware and infrastructure environments of the electronic AER form and OBS Database/AER Database application and develop a transition plan for subsuming the implementation and support activities from the existing Contractor.
11. Conduct maintenance and support activities on a regular scheduled basis for the OBS Dashboard/AER applications according to the description in the RFP scope of work.
12. Submit a change management plan.

3) Provider Network and Panel Data Systems

Describe the Bidder's approach to the following:

1. Build a data intake website for analysis, communication, tracking, and reporting system to be used by health plans and the State DOH.
2. Produce a development plan for the creation and maintenance of a data submission system that continuously accepts data and houses reference data and reports, with a full assessment of the business, software, hardware and infrastructure environments of PNDS and Panel, and institute the approved plan.
3. Handle special processing according to changes that occur and submit a change management plan to the State DOH for approval.
4. Validate plan-submitted data files to ensure the data comply with specifications, and, for discrepancies, work with the State DOH and plan to reconcile files.
5. Provide technical assistance to plans regarding data element formats and submission tool issues.
6. Build and maintain a data intake portal at a State DOH-approved domain according to the criteria referenced in the RFP scope of work.

7. Create a dashboard within the portal that can be updated as needed to convey information to users according to the criteria referenced in the RFP scope of work.
8. Build a tracking application within the portal that allows administrators to flag plan-reported data as suspicious or inaccurate.
9. Build several data extracts to be delivered to the State DOH on a recurring basis according the description in the RFP scope of work.
10. Upload the extracts to the State DOH using the Medicaid Data Mart and provide CSV files, perform a quality review on all reports prior to submitting them to the State DOH and provide the State DOH with a summary of findings.
11. Develop a web API to share PNDS data to and from the intake system and the State DOH's APD, or other systems within the State DOH as needed.
12. Make all originally submitted data, as well as standardized data, available to the State DOH through a querying tool.
13. Make data summary reports, as detailed in the RFP scope of work, available to the State DOH and continuously update the reports in real-time as new data are collected, and develop other reports as needed by the State DOH.
14. Flag providers using lists of sanctioned or otherwise excluded providers in plans' submissions.
15. For the reference data library, develop and maintain the necessary reference data and adhere to a monthly schedule for updates, create user guides for each user type, keep a library of current and past system validation rules and create a page on the portal where health plans can upload supplemental information not included in their submission.
16. For the PNDS Look-up Search Tool, build and maintain a Look-Up site, maintain a contact page within the site, build a feedback loop, log all inquiries/reports and make the log available weekly to the State DOH, refresh the data daily, use a development site to display and test each refresh, manipulate the data for consumer-friendly display, make updates to the site, conduct reviews of the tool's functionality and submit a quarterly review report weekly.
17. For system support and analysis, supply a system architecture document to the State DOH and work with ITS, create a support ticketing system, build functionality for automatic reminders, contract with a third party to perform a full vulnerability scan, make utilization statistics available to the State DOH and perform Project Management according to the RFP Scope of Work.

4) Sepsis Care Improvement Initiative

Describe the Bidder's approach to the following:

1. Develop or revise a web-based data collection/submission portal and database for each measurement year according to the specifications in the RFP Scope of Work and provide technical assistance to users of the portal, maintenance for the data collection system and develop a tool for hospitals for data abstraction.
2. Provide ongoing technical assistance to hospitals regarding quality performance data collection and validation and serve as a liaison between the hospitals and State DOH, and organize and participate in biannual conference calls.
3. Prepare and distribute reports in Tableau, prepare and update measure specifications, prepare and maintain a data dictionary and maintain a log of changes and make it available on the Sepsis Initiative website, and monitor the CMS data dictionary for changes.
4. Analyze data to identify hospitals that submitted data with inconsistencies and generate a hospital exception report and correct the files while maintaining the log of changes.
5. Develop and implement a data validation process for quarterly data, enable and facilitate submission of targeted and/or complete medical records and validate 10% of cases and identify and report findings to the State DOH; develop a report for hospitals, identify and maintain a contact list for email notification of non-compliance and send notices to hospitals; and provide technical and clinical assistance to hospital abstractors and clinical staff on validation discrepancies.
6. Analyze quarterly hospital performance data and prepare and distribute quarterly reports to each hospital.
7. Provide the State DOH with a final data set of all records as they are submitted to hospitals and a data set with resolved data inconsistencies to the State DOH, up to one (1) additional data set per quarter and all SAS, SQL or other coding language programs.

8. Prepare a comprehensive dataset which includes data from all reporting hospitals in the State for the calendar year.
9. Develop and maintain the Sepsis Initiative landing web page according to the specifications in the RFP Scope of Work.

5) State Health Profiles: Hospitals, Nursing Homes, Home Care, Hospice, and Adult Care Facilities

Describe the Bidder's approach to the following:

1. Develop, host, implement, maintain and update a consumer-friendly website according to the specifications in the RFP Scope of Work.
2. Develop and maintain the data including architecture for data sharing, transfer the methodology or code used for analytics to the State DOH and maintain data submission list servs or another process to manage the monthly and quarterly data submission process.
3. Provide adequate and necessary hardware, software and bandwidth and display on-demand profiles according to the specifications in the RFP Scope of Work.
4. Determine additional data sources, design elements, programming and metadata necessary for enhancements and ensure continuity of current website document storage, develop and update data and coding schedules and disseminate information and monthly progress reports, and maintain a mechanism to receive questions from users.
5. Continue to incorporate mapping and geocoding for provider-level maps and a quality grading system, including map improvements to ensure they are consumer friendly.
6. Enable specific searches, queries, and filtering requirements according to the specifications in the RFP Scope of Work.
7. Assess and identify the universe of potential quality and safety measures, and evaluate specific parameters; and add new measures, metrics and other information as they become available.
8. Manage ongoing projects for short cycle rapid development.
9. Research other state and national websites and provide recommendations on best practices.

6) Special Studies and Improvement Projects

The Bidder should provide their proposed approach to support new and ongoing quality improvement activities.

7) Written Reports, Data Systems and Data Security

Describe the Bidder's approach to the following:

1. Prepare formal reports to summarize the end of projects as specified in the RFP Scope of Work.
2. Maintain computer and data collection system(s) according to the specifications in the RFP Scope of Work.
3. Maintain a data processing system for backup and recovery according to the specifications in the RFP Scope of Work.
4. Maintain data security according to the specifications in the RFP Scope of Work.
5. Provide reports to the State DOH on its activities.
6. Participate in monitoring and reporting responsibilities according to the RFP Scope of Work.

D5. Transition Plan

When this contract concludes, the Contractor must cooperate with the successor contractor while providing all required transition services. This will include meeting with the successor and devising work schedules that are agreeable for both the State DOH and the successor Contractor. A description of such a transition plan should be included in the proposal.

6.3 Cost Proposal

Submit a completed and signed [Attachment B – Cost Proposal](#). The Cost Proposal shall comply with the format and content requirements as detailed in this document and in Attachment B. Failure to comply with the format and content requirements may result in disqualification.

The bid price is to cover the cost of furnishing all of the said services, including but not limited to travel, materials, equipment, overhead, profit and labor to the satisfaction of the State DOH and the performance of all work set forth in said specifications.

7.0 PROPOSAL SUBMISSION

A proposal consists of three distinct parts: (1) the Administrative Proposal, (2) the Technical Proposal, and (3) the Cost Proposal. The table below outlines the requested format and volume for submission of each part. Proposals should be submitted in all formats as prescribed below.

	Electronic Submission	Paper Submission
Administrative Proposal	2 dedicated flash drives or CDs labeled "Administrative Proposal" containing a standard searchable PDF file with copy/read permissions only.	4 Originals 6 Copies
Technical Proposal	2 dedicated flash drives or CDs labeled "Technical Proposal" containing a standard searchable PDF file with copy/read permissions only.	4 Originals 6 Copies
Cost Proposal	2 dedicated flash drives or CDs labeled "Cost Proposal" containing standard searchable PDF file(s) with copy/read permissions only.	4 Originals 6 Copies

1. All hard copy proposal materials should be printed on 8.5" x 11" white paper (single-sided) and **be clearly page numbered on the bottom of each page with appropriate header and footer information.** A font size of eleven (11) points or larger should be used. The Technical Proposal materials should be presented separate from the sealed Cost Proposal;
2. Where signatures are required, the proposals designated as originals should have a handwritten signature and be signed in blue ink.
3. The State DOH discourages overly lengthy proposals. Therefore, marketing brochures, user manuals or other materials, beyond that sufficient to present a complete and effective proposal, are not desired. Elaborate artwork or expensive paper is not necessary or desired. In order for the State DOH to evaluate proposals fairly and completely, proposals should follow the format described in this RFP to provide all requested information. The Bidder should not repeat information in more than one section of the proposal. If information in one section of the proposal is relevant to a discussion in another section, the Bidder should make specific reference to the other section rather than repeating the information;
4. Audio and/or videotapes are not allowed. Any submitted audio or videotapes will be ignored by the evaluation team; and
5. In the event that a discrepancy is found between the electronic and hardcopy proposal, the original hardcopy will prevail.

The proposal must be received by the State DOH, no later than the Deadline for Submission of Proposals specified in [Section 1.0, \(Calendar of Events\)](#). Late bids will not be considered.

Proposals should be submitted in three (3) separate, clearly labeled packages: (1) Administrative Proposal, (2) Technical Proposal and (3) Cost Proposal, prepared in accordance with the requirements stated in this RFP. Mark the outside envelope of each proposal as "RFP# 20062(Medicaid External Quality Review and Other Activities in New York State) – (Administrative) (Technical) or (Cost) Proposal submitted by (Bidder's name)". The three (3) sealed proposals may be combined into one (1) mailing, if desired.

Proposals must be submitted, by U.S. Mail, by courier/delivery service (e.g., FedEx, UPS, etc.) or by hand as noted below, in a sealed package to:

Department of Health (RFP # 20062)
Attention:
New York State Department of Health
Office of Quality and Patient Safety
Room 2084, Corning Tower
Albany, NY 12237

NOTE: You should request a receipt containing the time and date received and the signature of the receiver for all hand-deliveries and ask that this information also be written on the package(s).

Submission of proposals in a manner other than as described in these instructions (e.g., fax, electronic transmission) will not be accepted.

7.1 No Bid Form

Bidders choosing not to bid are requested to complete the No-Bid form [Attachment 2](#).

8.0 METHOD OF AWARD

8.1 General Information

DOH will evaluate each proposal based on the "Best Value" concept. This means that the proposal that best "optimizes quality, cost, and efficiency among responsive and responsible offerers" shall be selected for award (State Finance Law, Article 11, §163(1)(j)).

DOH at its sole discretion, will determine which proposal(s) best satisfies its requirements. DOH reserves all rights with respect to the award. All proposals deemed to be responsive to the requirements of this procurement will be evaluated and scored for technical qualities and cost. Proposals failing to meet the requirements of this document may be eliminated from consideration. The evaluation process will include separate technical and cost evaluations, and the result of each evaluation shall remain confidential until evaluations have been completed and a selection of the winning proposal is made.

The evaluation process will be conducted in a comprehensive and impartial manner, as set forth herein, by an Evaluation Committee. The Technical Proposal and compliance with other RFP requirements (other than the Cost Proposal) will be weighted **75%** of a proposal's total score and the information contained in the Cost Proposal will be weighted **25%** of a proposal's total score.

Bidders may be requested by DOH to clarify the contents of their proposals. Other than to provide such information as may be requested by DOH, no Bidder will be allowed to alter its proposal or add information after the Deadline for Submission of Proposals listed in [Section 1.0](#) (Calendar of Events).

In the event of a tie, the determining factors for award, in descending order, will be:

- (1) lowest cost and
- (2) proposed percentage of MWBE participation.

8.2 Submission Review

DOH will examine all proposals that are received in a proper and timely manner to determine if they meet the proposal submission requirements, as described in [Section 6.0](#) (Proposal Content) and [Section 7.0](#) (Proposal Submission), including documentation requested for the Administrative Proposal, as stated in this RFP. Proposals that are materially deficient in meeting the submission requirements or have omitted material documents, in the sole opinion of DOH, may be rejected.

8.3 Technical Evaluation

The evaluation process will be conducted in a comprehensive and impartial manner. A Technical Evaluation Committee comprised of program staff of DOH will review and evaluate all proposals.

Proposals will undergo a preliminary evaluation to verify Minimum Qualifications to Propose (Section 3.0).

The Technical Evaluation Committee members will independently score each Technical Proposal that meets the submission requirements of this RFP. The individual Committee Member scores will be averaged to calculate the Technical Score for each responsive Bidder.

The technical evaluation is **75% (up to 75 points)** of the final score.

8.4 Cost Evaluation

The Cost Evaluation Committee will examine the Cost Proposal documents. The Cost Proposals will be opened and reviewed for responsiveness to cost requirements. If a cost proposal is found to be non-responsive, that proposal may not receive a cost score and may be eliminated from consideration.

The Cost Proposals will be scored based on a maximum cost score of 25 points. The maximum cost score will be allocated to the proposal with the lowest all-inclusive not-to-exceed maximum price. All other responsive proposals will receive a proportionate score based on the relation of their Cost Proposal to the proposals offered at the lowest final cost, using this formula:

$$C = (A/B) * 25\%$$

A is Total price of lowest cost proposal;

B is Total price of cost proposal being scored; and

C is the Cost score.

The cost evaluation is **25% (up to 25 points)** of the final score.

8.5 Composite Score

A composite score will be calculated by the DOH by adding the Technical Proposal points and the Cost points awarded. Finalists will be determined based on composite scores.

8.6 Reference Checks

The Bidder should submit references using [Attachment 9](#) (References). At the discretion of the Evaluation Committee, references may be checked at any point during the process to verify Bidder qualifications to propose (Section 3.0).

8.7 Best and Final Offers

State DOH reserves the right to request best and final offers. In the event State DOH exercises this right, all Bidders that submitted a proposal that are susceptible to award will be asked to provide a best and final offer. Bidders will be informed that should they choose not to submit a best and final offer, the offer submitted with their proposal will be construed as their best and final offer.

8.8 Award Recommendation

The Evaluation Committee will submit a recommendation for award to the Finalist(s) with the highest composite score(s) whose experience and qualifications have been verified.

The State DOH will notify the awarded Bidder(s) and Bidders not awarded. The awarded Bidder(s) will enter into a written Agreement substantially in accordance with the terms of [Attachment 8](#), DOH Agreement, to provide the required services as specified in this RFP. The resultant contract shall not be binding until fully executed and approved by the New York State Office of the Attorney General and the Office of the State Comptroller.

ATTACHMENTS

The following attachments are included in this RFP and are available via hyperlink or can be found at: <https://www.health.ny.gov/funding/forms/>.

1. [Bidder's Disclosure of Prior Non-Responsibility Determination](#)
2. [No-Bid Form](#)
3. [Vendor Responsibility Attestation](#)
4. [Vendor Assurance of No Conflict of Interest or Detrimental Effect](#)
5. [Guide to New York State DOH M/WBE Required Forms & Forms](#)
6. [Encouraging Use of New York Businesses in Contract Performance](#)
7. [Bidder's Certified Statements](#)
8. [DOH Agreement](#) (Standard Contract)
9. [References](#)
10. [Diversity Practices Questionnaire](#)
11. [Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination](#)

The following attachments are attached and included in this RFP:

- A. Proposal Document Checklist
- B. Cost Proposal
- C. EQR Deliverables Schedule
- D. [Annual Volumes](#)
- E. [Transmittal Form](#)

ATTACHMENT A
PROPOSAL DOCUMENT CHECKLIST

Please reference Section 7.0 for the appropriate format and quantities for each proposal submission.

RFPXX-XX – TITLE OF RFP		
FOR THE ADMINISTRATIVE PROPOSAL		
RFP §	SUBMISSION	INCLUDED
§ 6.1.A	Attachment 1 – Bidder’s Disclosure of Prior Non-Responsibility Determinations, completed and signed.	<input type="checkbox"/>
§ 6.1.B	Freedom of Information Law – Proposal Redactions (If Applicable)	<input type="checkbox"/>
§ 6.1.C	Attachment 3- Vendor Responsibility Attestation	<input type="checkbox"/>
§ 6.1.E	Attachment 4 - Vendor Assurance of No Conflict of Interest or Detrimental Effect	<input type="checkbox"/>
§ 6.1.F	M/WBE Participation Requirements:	<input type="checkbox"/>
	Attachment 5 Form 1	<input type="checkbox"/>
	Attachment 5 Form 2 (If Applicable)	<input type="checkbox"/>
§ 6.1.G	Attachment 6- Encouraging Use of New York Businesses	<input type="checkbox"/>
§ 6.1.H	Attachment 7 - Bidder’s Certified Statements, completed & signed.	<input type="checkbox"/>
§ 6.1.I	Attachment 9 – References	<input type="checkbox"/>
§ 6.1.J	Attachment 10 - Diversity Practices Questionnaire	<input type="checkbox"/>
§ 6.1.K	Attachment 11 - Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination	<input type="checkbox"/>
FOR THE TECHNICAL PROPOSAL		
RFP §	SUBMISSION	INCLUDED
§ 6.2.A	Title Page	<input type="checkbox"/>
§ 6.2.B	Table of Contents	<input type="checkbox"/>
§ 6.2.C	Documentation of Bidder’s Eligibility (Requirement)	<input type="checkbox"/>
§ 6.2.D	Technical Proposal Narrative	<input type="checkbox"/>
FOR THE COST PROPOSAL REQUIREMENT		
RFP §	REQUIREMENT	INCLUDED
§ 6.3	Attachment B- Cost Proposal	<input type="checkbox"/>

ATTACHMENT B

Cost Proposal Forms

This RFP will result in a fixed price contract based on the successful Bidder’s total bid amount. Payments to the Contractor will be based on satisfactory completion of deliverables, as described in section VII. Proposal Requirements, subsection c) - Cost Proposal. Information requested concerning hourly rates and number of hours required are for informational purposes only.

Cost Proposal Form 1: Calculate a bid price for each activity described below, relating to services described in section IV of the RFP, ‘Contractor Services’. The calculated unit price for External Quality Review Services should be multiplied by the estimated first year volume to determine the total price for the activity.

For each of the activities listed in the Project Specifications – Scope of Work, provide a unit price for each proposed deliverable. All administrative costs should be included in the unit prices. See Attachment C – EQR Work Activity Volume and Frequency Schedule, for more information on the volume and frequencies of activities associated with External Quality Review.

Activity 1. External Quality Review Services

	Work Plan Activity (Estimated annual volume)	Unit Definition	Unit Price
1)	Validation of PIPs (13 MMC, 12 HARP, 3 HIV SNP, 45 MLTC plans)	One plan PIP validation	
2)	Validation of Performance Measures		
1	MCO Quality Data (up to 40 MCOs and 80 lines of business)	One summary finding report	
2	Validation of Functional Assessment Data (1 annually)	One validation study	
3)	Review of Compliance with Medicaid Regulations		
1	Provider Directory Survey (twice annually)	One survey administration	
2a	Provider Access and Availability Survey – Primary Care/OB-GYN (Average of 2400 calls)	One survey administration	
2b	Provider Access and Availability Survey – Behavioral Health (Average of 1000 calls)	One survey administration	
3	Plan Member Services Survey (Average of 480 calls)	One survey administration	
4	High-Volume Enrollee to Provider Ratio Survey (Average of 800 calls)	One survey administration	
4)	Validating Network Adequacy (16 templates, 350 networks)	One network validation tool	
5)	Validation of Encounter Data	One validation study	

Bidder _____

6)	Administration of Consumer Surveys		
1	CAHPS (31 adult CAHPS, 15 child CAHPS)	One survey administration	
2	Experience of Care Surveys (500 per plan)	One survey administration	
7)	Calculation of Performance Measures (1 annually)	1 Measure Development	
8)	Conduct Studies on Healthcare Quality		
	Focused Clinical Study – MMC (600 records)	One study	
	Conduct Focused Clinical Study – HARP (400 records)	One study	
	Behavioral Health Focused Study – MLTC (400 <u>200</u> records)	One study	
9)	Annual Plan Technical Reports (13 MMC, 12 HARP, 3 HIV-SNP, 45 MLTC plans)	One set of annual reports	
10)	Focus Groups (12 sessions over contract period)	One session	

Bidder _____

Cost Proposal Form 2

For each of the activities listed in the Project Specifications – Scope of Work, provide a unit price for each proposed deliverable. All administrative costs should be included in the unit prices.

Activity 2. Office Based Surgery

	Work Plan Activity (Estimated annual volume)	Unit Definition	Unit Price
1)	Quality of Care Review (average of 630 reviews per year)	One Review	
2)	Adverse Event Reporting form and Dashboard		
1	Conduct assessment of business requirements and receive approval for transition plan	One-time cost	
2	Complete activities required for transition of the Adverse Event Reporting form and Dashboard	One-time cost	
3	Maintenance and Support Fee	Recurring monthly cost	
4	Help desk Fee	Recurring monthly cost	
3)	Hourly Rates for change requests will be based on the rates included in Special Studies and Improvement Projects. The titles that are applicable to this section include: Specialist Physician; Project Manager; Database Administrator; Computer Programmer; Data Analyst; and, Web Designer		

Cost Proposal Form 3

For each of the activities listed in the Project Specifications – Scope of Work, provide a unit price for each proposed deliverable. All administrative costs should be included in the unit prices.

Activity 3. Provider Network Data System

	Work Plan Activity (Estimated annual volume)	Unit Definition	Unit Price
1)	Development of a data intake website	One-time cost	
1	Development of data submission system within data intake website	One-time cost	
2)	Development of data intake portal	One-time cost	
1	Development of dashboard within intake portal	One-time cost	
2	Development of a deficiency tracking system within intake portal	One-time cost	
3	Development of API to share data	One-time cost	
4)	Development of data extract and reporting system	One-time cost	
1	Creation of monthly and quarterly data extract (7 reports)	One report	
2	Creation of real-time extract (12 reports)	One report	
6)	Development of file sharing area within reference library	One-time cost	
7)	Validation of plan-submitted data files	Recurring monthly cost	
8)	Maintenance and Support Fee (systems support, data correction, real-time data refresh, technical support, provision of analytics)	Recurring monthly cost	
9)	Hourly Rates for change requests will be based on the rates included in Special Studies and Improvement Projects. The titles that are applicable to this section include: Project Manager; Database Administrator; Computer Programmer; Data Analyst; and, Web Designer		

Cost Proposal Form 4

For each of the activities listed in the Project Specifications – Scope of Work, provide a unit price for each proposed deliverable. All administrative costs should be included in the unit prices.

Activity 4. Sepsis Care Improvement Initiative

	Work Plan Activity (Estimated annual volume)	Unit Definition	Unit Price
1)	Development of a web-based data collection and submission portal	One-time cost	
2)	Development of a public-facing Sepsis Initiative webpage with secure login	One-time cost	
3)	Development and distribution of reports to hospitals	One report	
4)	Quarterly validation and correction of hospital performance data	One final report	
5)	Maintenance and support fee (Sepsis Initiative landing page, ongoing technical assistance to hospitals, liaising between DOH and hospitals, data correction)	Monthly cost	
6)	Organizing and participating in bi-annual hospital conference call	One meeting	
7)	Hourly Rates for change requests will be based on the rates included in Special Studies and Improvement Projects. The titles that are applicable to this section include: Project Manager; Database Administrator; Computer Programmer; Data Analyst; and, Web Designer		

Cost Proposal Form 5

For each of the activities listed in the Project Specifications – Scope of Work, provide a unit price for each proposed deliverable. All administrative costs should be included in the unit prices.

Activity 5. State Health Profiles: Hospitals, Nursing Homes, Home Care, Hospice and Adult Care Facilities

	Work Plan Activity (Estimated annual volume)	Unit Definition	Unit Price
1)	Development and implementation of a public facing website	One-time cost	
2)	Development and implementation of architecture for data sharing across multiple applications	One-time cost	
3)	Data Updates (Nursing Home and Adult Care facilities)	Recurring Monthly Cost	
4)	Data Updates (Hospital and Home Care facilities)	Recurring Quarterly Cost	
5)	Help desk fee	Recurring Monthly Cost	
6)	Maintenance and Support fee	Recurring Monthly Cost	
7)	Hourly Rates for change requests will be based on the rates included in Special Studies and Improvement Projects. The titles that are applicable to this section include: Project Manager; Database Administrator; Computer Programmer; Data Analyst; and, Web Designer		

Cost Proposal Form 6

Hourly Personnel Rates

Hourly staff rates are requested for Special Studies, quality assistance, and change requests. List the titles and composite hourly rates for each type of staff person who will work on these projects. Personnel types should fit into the existing categories. Do not add additional titles.

The composite hourly rates described must be inclusive of all costs, including salaries, fringe benefits, administrative costs, overhead, travel, presentation costs, and profit. These composite hourly rates will apply for the entire contract period. Staff may be required to be onsite at DOH locations in and around Albany, NY.

Staff Listing	Price/Hour
Registered Nurse / Nurse Practitioner	
General Physician	
Specialist Physician (“Specialized” means board certified in an area that DOH deems appropriate to the subject matter being supported)	
Physician Assistant	
Psychologist	
Nurse Case Manager	
Medical Records Coder	
Project Manager	
Secretarial / Clerical Staff	
Web Designer	
Information Technology Security Analyst	
ETL Developer	
Database Administrator	
Systems Administrator	
Computer Programmer	
Statistician	
Data Analyst	
Researcher	
Technical Writer	

This table lists the estimated hours for the currently defined Special Studies per annum. These Special Studies are projected to last for the duration of the contract. Future Special Studies may use staff titles not utilized at the start of the contract.

Staff Listing	MIS-C	Centering Pregnancy	Doula Surveys
Registered Nurse / Nurse Practitioner	1440	350	-
General Physician	720	176	-
Specialist Physician (“Specialized” means board certified in an area that DOH deems appropriate to the subject matter being supported)	-	-	-
Physician Assistant	-	-	-
Psychologist	-	-	-
Nurse Case Manager	-	-	-
Medical Records Coder	-	-	-
Project Manager	720	176	90
Secretarial / Clerical Staff	-	-	80
Web Designer	-	-	-
Information Technology Security Analyst	-	-	-
ETL Developer	-	-	-
Database Administrator	-	-	-
Systems Administrator	-	-	-
Computer Programmer	180	-	-
Statistician	-	-	-
Data Analyst	540	100	-
Researcher	-	-	-
Technical Writer	-	50	-

<ul style="list-style-type: none"> Report to the State DOH its findings in the EQR Technical Report. 	D.4.1.1.i	
<ul style="list-style-type: none"> <i>Host conference to share best practices with MCOs</i> Conduct meetings, in person conferences, workshops or webinars to share the results and promising practices. 		10%
4.1.1.2 Validation of Performance Measures		
Project 1.) MCO Quality Data		
<p><i>Submit validated MCO files to State DOH</i></p> <ul style="list-style-type: none"> Develop a submission platform that allows secure file transfer from plans to the Contractor for all required QARR files, such as audit findings, State-specific measures, person-level detail files, birth files and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) files. Validate its functionality with State DOH through test files. Create a data submission tool to collect New York State-specific measures and revise the tool annually as needed. They will also validate its functionality with State DOH through test files. Provide external oversight of the QARR submission process. Ensure the accuracy of the data and submit a summary report of findings. Provide annual technical assistance and training to MCOs. Assist the State DOH with QARR measure specifications, review and validate source code, develop and host an annual webinar for MCO staff, provide training and technical assistance to MCOs when new measures are incorporated and collect data from MCOs and provide these to the State DOH. Monitor that all required files are submitted by the deadline, perform a preliminary data check to identify any quality issues, and document extent of correctness in a preliminary findings report to the State DOH. Compile and validate files into large datasets used by the State DOH annually. Compare data reported via the data submission tool and patient-level detail files and reconcile discrepancies with plans prior to submission to State DOH. Aggregate quality sets and patient-level detail files into large dates for the State DOH . 	D.4 1) 2. f i-viii	55%
<p><i>Data accuracy summary findings report</i></p> <ul style="list-style-type: none"> Contractor will ensure the accuracy of the data submitted through the QARR process and submit a summary report of findings from their annual QARR submission quality check to the State DOH. Document the extent to which the MCO calculated the performance measures correctly in the preliminary findings report. 	D.4 1) 2. f. ix-x	25%

<ul style="list-style-type: none"> Review NCQA-certified auditors' Compliance Audit Final Report designations and findings to further assess the accuracy of measures and the extent to which measures follow specifications and reporting requirements. Provide ongoing technical assistance to MCOs, serve as liaison between MCOs, NCQA subcontractors and the State DOH, and participate in meetings with key MCO personnel to assist in implementing corrective actions. 		
<p><i>QARR measure specification review and validation</i></p> <ul style="list-style-type: none"> Annually review and validate source code for select State-specific QARR measures, including new measures and enhancements. 		10%
<p><i>QARR Technical Webinar and Plan Communications</i></p> <ul style="list-style-type: none"> Develop and host an annual technical webinar for MCO staff (QARR participants) on collecting and submitting QARR data which will focus on new or revised QARR/HEDIS® requirements, changes in data submission, validation procedures including any changes, measure calculations, specifications and techniques to optimize QARR/HEDIS® reporting. Provide training and technical assistance to all MCOs when new quality and performance measures are incorporated into QARR reporting which can be done through the webinar and through emails and phone calls with the MCOs. 		10%
Project 2.) Validation of Functional Assessment Data		
<p><i>Submit study proposal</i></p> <ul style="list-style-type: none"> Prepare and submit a data validation proposal to the State DOH for approval with consideration of possible amendments needed for newer plans and refining the proposal based on State DOH feedback. Develop the study methodology including study questions, selected indicators, identified study population, sampling methods, data collection procedures, improvement strategies, and data analysis methods. Share written comments on the study methodology with the State DOH. Review final proposal with comments addressed and submit proposal to the State DOH. Prepare and send written correspondence to community-based providers and schedule visits with them or request medical records submission by the plans. Conduct the data validation after receiving the records, submit a draft report to the State DOH, send the draft report to the providers for response, update the report, submit the report to the State DOH for approval and send the final validation reports to the plans. 	D.4 1) 2. g. i-iv	20%
<p><i>Submit regular progress reports</i></p> <ul style="list-style-type: none"> Perform timely validations of data to ensure integrity for program functions and submit draft and final reports to the State DOH. 		20%

<ul style="list-style-type: none"> Submit regular progress reports utilizing State DOH approved project management tool 		
<ul style="list-style-type: none"> <i>Submit summary report to the State DOH</i> Draft template of report and draft report shared with the State DOH according to approved timeline. Incorporate State DOH comments/suggestions. Final report submitted by deadline. 		60%
4.1.1.3 Review of Compliance with Medicaid Regulations		
Follow CMS' EQR Protocols for Medicaid and CHIP Managed Care regulations compliance review		
<ul style="list-style-type: none"> <i>Establish compliance thresholds</i> Under guidance of the State DOH, develop a protocol for administration of the survey. The protocol must be approved by State DOH staff and will at a minimum describe the threshold for reaching a determination. 	D.4 1) 3.a	10%
<ul style="list-style-type: none"> <i>Perform Preliminary Review</i> Complete pre-onsite visit activities as outlined in the RFP (establish contact with the MCO; perform a document review) 	D.4 1) 3.b	10%
<ul style="list-style-type: none"> <i>Conduct MCO onsite visit</i> Complete onsite visit for each MCO as outlined in the RFP (determine onsite visit length and dates; identify the number and types of reviewers needed; develop and onsite visit agenda; provide preparation instructions and guidance to the MCO; MCO interviews; conduct exit MCO interviews) 	D.4 1) 3.c	50%
<ul style="list-style-type: none"> <i>Compile and Analyze Findings</i> Collect supplemental information, compile data and information, and analyze findings 	D.4 1) 3.d	15%
<ul style="list-style-type: none"> <i>Report Results to State DOH</i> Determine if compliance with each state and federal standard was met for each MCO; analyze findings; and prepare a narrative that outlines compliance determinations. Submit the report to the State for review and revision. Revise as advised. 	D.4 1) 3.d	15%
Project 1.) Provider Directory Summary		
<ul style="list-style-type: none"> <i>Develop Protocol</i> Conduct a validation of Medicaid MCO web-based provider directories twice a year. Under guidance of the State DOH, develop a protocol for administration of the survey. The protocol must be approved by the State DOH staff and will at minimum describe the threshold for reaching a determination. 	D.4 1) 3.i.i & D.4 1) 3.i.iii	10%
<ul style="list-style-type: none"> <i>Generate Random Sample</i> Generate a random sample of providers for survey for each MCO, stratified by provider specialty, using the available web-based Provider Directories maintained by each MCO. 	D.4 1) 3.i.v	15%
<ul style="list-style-type: none"> <i>Administer Calls</i> Administer calls to provider offices to obtain confirmation of PCP participation in MCO network, specialty, Medicaid panel status, physical location and phone number. Track success rates and report discrepancies to the MCO for correction 	D.4 1) 3.i.i & D.4 1) 3.i.ii & D.4 1) 3.i.iii	50%

<p><i>Final Reports on Results and Determinations for all MCOs</i></p> <ul style="list-style-type: none"> Produce a summary report of survey findings for each MCO, including a determination of compliance per requirements set forth in the State's Medicaid Model Contract. Submit the report to the State for review and revision. Revise as advised. 	D.4 1) 3.i.v	25%
Project 2a) Provider Access and Availability Survey – Primary Care/OB-GYN		
<p><i>Develop Protocol</i></p> <ul style="list-style-type: none"> Under guidance of the State DOH, develop a protocol for administration of the survey. The protocol must be approved by State DOH staff and will at minimum describe the frequency and periodicity that calls will occur, and the threshold for reaching a determination. 	D.4 1) 3.j.i & D.4 1) 3.j.iii	15%
<p><i>Generate Random Sample</i></p> <ul style="list-style-type: none"> Generate a random sample of providers for survey for each MCO, stratified by provider specialty, using the available web-based Provider Directories maintained by each MCO. Remove non-participating providers. 	D.4 1) 3.j.iii.1	10%
<p><i>Scripted Scenarios</i></p> <ul style="list-style-type: none"> Prepare and update scripted scenarios for the survey. Scenarios must be reviewed and approved by the State DOH. 	D.4 1) 3.j.i	5%
<p><i>Administer Calls</i></p> <ul style="list-style-type: none"> Administer calls according to the four (4) scenarios in the RFP and track success rates using the template provided in the RFP and include plans that did not meet the threshold in the next round of the access and availability survey. 	D.4 1) 3.j.iii.2	50%
<p><i>Final Reports on Results and Determinations for all MCOs</i></p> <ul style="list-style-type: none"> Produce a summary report of survey findings for each MCO, including a determination of compliance per requirements set forth in the State's Medicaid Model Contract. Submit the report to the State for review and revision. Revise as advised. 	D.4 1) 3.j.ii & D.4 1) 3.j.iii.3	20%
Project 2b) Provider Access and Availability Survey – Behavioral Health		
<p><i>Develop Protocol</i></p> <ul style="list-style-type: none"> Under guidance of the State DOH, OMH, and OASAS, develop a protocol for administration of the survey. The protocol must be approved by State DOH staff and will at minimum describe the frequency and periodicity that calls will occur, and the threshold for reaching a determination. 	D.4 1) 3.j.i & D.4 1) 3.j.iv	15%
<p><i>Generate Random Sample</i></p> <ul style="list-style-type: none"> Generate a random sample of providers for survey for each MCO, stratified by provider specialty, using the available web-based Provider Directories maintained by each MCO. 	D.4 1) 3.j.iv.1	10%
<p><i>Scripted Scenarios</i></p>	D.4 1) 3.j.i	5%

<ul style="list-style-type: none"> Prepare and update scripted scenarios for the survey. Scenarios must be reviewed and approved by OMH and OASAS. 		
<p><i>Administer Calls</i></p> <ul style="list-style-type: none"> Administer calls according to the two (2) scenarios in the RFP and track success rates using the template provided in the RFP and include plans that did not meet the threshold in the next round of the access and availability survey. 	D.4 1) 3.j.iv.2	50%
<p><i>Final Reports on Results and Determinations for all MCOs</i></p> <ul style="list-style-type: none"> Produce a summary report of survey findings for each MCO, including a determination of compliance per requirements set forth in the State's Medicaid Model Contract. Submit the report to the State for review and revision. Revise as advised. 	D.4 1) 3.j.ii	20%
Project 3.) Plan Member Services Survey		
<p><i>Sampling Tool</i></p> <ul style="list-style-type: none"> Prepare sampling tool. 	D.4 1) 3.g & D.4 1) 3.j.v	10%
<p><i>Finalize Scripted Scenarios</i></p> <ul style="list-style-type: none"> Select questions to be used from scripted scenarios prepared by the State DOH, confirming questions and correct responses with the State DOH 	D.4 1) 3.g & D.4 1) 3.j.v	5%
<p><i>Administer First Round of Calls</i></p> <ul style="list-style-type: none"> Conduct the telephone surveys using scripted scenarios and record results on the survey tool. 	D.4 1) 3.j.v.1	35%
<p><i>First Round Final Report</i></p> <ul style="list-style-type: none"> Prepare and transmit draft report for each health plan to State DOH for review and approval. Submit final revised report within 60 days of survey completion. 	D.4 1) 3.j.v.1	10%
<p><i>Administer Second Round of Calls</i></p> <ul style="list-style-type: none"> At the direction of the State DOH, conduct follow-up telephone calls in next six (6) months for all questions answered incorrectly. 	D.4 1) 3.j.v.2	25%
<p><i>Final Reports</i></p> <ul style="list-style-type: none"> Prepare and transmit report for each health plan follow-up to the State DOH for review and approval. Submit final report within 60 days of 2nd Round completion. 	D.4 1) 3.j.v.2	15%
Project 4.) High-Volume Enrollee to Provider Ratio Survey		
<p><i>Complete Data Collection Tool</i></p> <ul style="list-style-type: none"> Develop data collection tool for State DOH approval. 	D.4 1) 3.j.vi.1	15%
<p><i>Administer Survey</i></p> <ul style="list-style-type: none"> Conduct the telephone surveys using scripted questions and record results on the survey tool. 	D.4 1) 3.j.vi.2	50%
<p><i>Draft Survey Findings Report</i></p> <ul style="list-style-type: none"> Calculate appointment availability rates. Prepare and transmit a draft findings report to the State DOH for review and approval. Prepare and submit draft notification letters for each MCO to the State DOH for review approval. 	D.4 1) 3.j.vi.2	20%
<p><i>Final Survey Findings Report</i></p> <ul style="list-style-type: none"> Revise draft report per State DOH specifications and submit final report. 	D.4 1) 3.j.vi.2	15%

<ul style="list-style-type: none"> Revise draft notification letters per State DOH specifications and submit letters and reports to the MCOs. 		
4.1.1.4 Validating Network Adequacy		
<p><i>Completion of Network Adequacy Standards Templates</i></p> <ul style="list-style-type: none"> Develop and maintain templates, which outline adequacy standards for each line of business. 	D.4 1) 4.a.ii	20%
<p><i>Perform Quarterly Adequacy Review</i></p> <ul style="list-style-type: none"> Quantify the number of providers and/or sites in each network, in each specialty, within a geographic region, and surrounding region. Evaluate accessibility of providers using time and distance standards. Quantify the number of providers and/or sites available in an overall market, a submitting plan market, and a product-specific market. Categorize unmet standards into deficiency types by plan and product. 	D.4 1) 4.a.i & D.4 1) 4.a.iii & D.4 1) 4.a.iv & D.4 1) 4.a.v	40%
<p><i>Perform Ad Hoc Adequacy Reviews</i></p> <ul style="list-style-type: none"> Repeat quarterly adequacy review tasks on an ad-hoc basis for individual plans 	D.4 1) 4.a.i & D.4 1) 4.a.iii & D.4 1) 4.a.iv & D.4 1) 4.a.v	10%
<p><i>Create Adequacy Review Dataset</i></p> <ul style="list-style-type: none"> Combine all-plan adequacy review results into a data set and share with the State DOH. 	D.4 1) 4.a.vi	15%
<p><i>Produce Report</i></p> <ul style="list-style-type: none"> Summarize adequacy findings and trend findings over time. 	D.4 1) 4.a.vi	5%
<p><i>Create Metadata</i></p> <ul style="list-style-type: none"> Create and maintain metadata that describes how analyses are performed. 	D.4 1) 4.a.vii	5%
<p><i>Technical Assistance</i></p> <ul style="list-style-type: none"> Provide technical assistance to the MCOs 	D.4 1) 4.a.viii	5%
4.1.1.5 Validation of Encounter Data		
<p><i>Design Protocol and Analysis Plan</i></p> <ul style="list-style-type: none"> Review State requirements. Design an annual encounter data validation strategy. Prepare a validation analysis plan for State DOH approval; evaluate the validity and completeness of data; assess new MCOs readiness to submit encounter data including developing and hosting a webinar to train new plans; analyze and provide technical assistance to plans regarding their use of vendors in data collection; continue evaluation of provider-sponsored information system capability; and assist plans in data and process quality improvement. Assist the State DOH in selecting plans and/or data items for audit based on analysis of completeness and compliance reports. 	D.4 1) 5. a-c D.4 1) 5. e	15%

<ul style="list-style-type: none"> Recommend the selection of plans and/or data items for validation. Determine sampling strategy to be used. Prepare a validation analysis plan and submit to the State DOH for review and comment. Revise as requested. 		
<p><i>Develop Chart Review Tool or Survey</i></p> <ul style="list-style-type: none"> Develop a chart review tool or survey to obtain information regarding internal and external factors in the data submission process and the role of external vendors or contractors. 		15%
<p><i>Complete Training Webinar</i></p> <ul style="list-style-type: none"> Develop and host a data submission training (webinar) for new plans, as necessary. 		5%
<p><i>Complete Validation</i></p> <ul style="list-style-type: none"> Request medical records or conduct surveys of MCOs Review medical records. 	D.4 1) 5.d	40%
<p><i>Final Report</i></p> <ul style="list-style-type: none"> Prepare a draft validation report and submit to the State DOH for review and comment. Prepare a final validation report detailing findings. 	D.4 1) 5.f	15%
<p><i>Distribute Plan Notification of Results and Final Reports</i></p> <ul style="list-style-type: none"> Prepare letters to plans and send electronically with final report. 		10%
4.1.1.6 Administration of Consumer Surveys		
Project 1.) CAHPS		
<p><i>Submit study proposal with methodology and questionnaire</i></p> <ul style="list-style-type: none"> Develop a workplan for State DOH approval. Develop the sampling plan. Develop a strategy to maximize the response rate. Develop a quality assurance plan. Propose a recruitment strategy with a two-to-three wave mailing and phone, request edits on the questionnaire from the State DOH, and discuss any needs for oversampling with underperforming plans. Work with the State DOH on confirmation of the sample with size per methodology needs. 	D.4 1) 6 b-c,e-g	55%
<ul style="list-style-type: none"> Implement the survey according to the work plan. Following the prescribed methodology, field the survey, plan for operational needs and staff time, deal with logistical issues related to mailing or phone, plan for intake of survey, provide periodic updates to the State DOH. 	D.4 1) 6 h	25%
<ul style="list-style-type: none"> Prepare and analyze survey data and present the results in a final report to the State DOH Draft reports with the data fully analyzed according to previous years formats should be produced for the State DOH review and feedback. 	D.4 1) 6 i	10%
<ul style="list-style-type: none"> Provide the State DOH with a final report, the data generated from the responses and prepare and submit the survey tools and data to AHRQ. Execute final copies of statewide, line of business-specific, and individual plan level reports for delivery to the State DOH.' 	D.4 1) 6 i	10%

Project 2.) Experience of Care Surveys		
<ul style="list-style-type: none"> Develop additional non-CAHPS® surveys, including the methodology, protocol, sampling, data collection and analysis, administration method, and tools. Identify the survey purpose, objectives and audience. Collaborate with the State DOH to determine a work plan and specific areas for analysis. Develop the sampling plan. Develop a strategy to maximize the response rate. Develop a quality assurance plan. Prepare a final proposal summarizing agreed upon study design and timeline and submit to the State DOH for approval. 	D.4 1) 6 d,e-g	10%
<p><i>Submit final survey tool and materials</i></p> <ul style="list-style-type: none"> Develop survey questions in draft scannable format and submit to the State DOH for review. Prepare and print final scannable survey and introductory letter. 		10%
<p><i>Submit Data Analysis Plan</i></p> <ul style="list-style-type: none"> Develop data analysis plan and submit to the State DOH for review and approval. 		10%
<p><i>Administer Survey</i></p> <ul style="list-style-type: none"> Conduct at least two (2) mailings of the survey and work with the State DOH to maximize response rates. 	D.4 1) 6 k ii	40%
<p><i>Final Data Set</i></p> <ul style="list-style-type: none"> Provide a member-level data set to the State DOH. 		5%
<p><i>Final Report</i></p> <p>Provide the State DOH with a final report, member-level data set of responses and participate in an annual conference call or on-site meeting with MCOs to discuss findings and improvement strategies.</p> <ul style="list-style-type: none"> Prepare draft report and submit to the State DOH for review. Prepare final report addressing comments from the State DOH. 	D.4 1) 6 k iii	20%
<p><i>Disseminate Survey Results</i></p> <ul style="list-style-type: none"> Host conference call or webinar with MCOs and/or other State agencies to discuss survey findings and improvement strategies. 		5%
4.1.1.7 Calculation of Performance Measures		
<ul style="list-style-type: none"> Prepare for measurement. Create the measures. Identify priority areas or gaps where measures are needed. Refine and finalize new measure topics. Review existing measures for comparison to candidate measures. Review existing studies that can be used as the evidence base for new measures. Compile scientific evidence using the National Quality Forum evidence criterion and complete a measure justification form. 	D.4 1) 7 a-f,h,n	20%

<p><i>Develop proposed NYS specific performance measure report</i></p> <ul style="list-style-type: none"> • Provide the State DOH with analysis plans, report formats, and draft reports for approval, and analyze and present the results to the State DOH and its stakeholders. • Produce a report that identifies priority areas or gaps where quality measures are needed based on analysis of existing quality measure data, review of peer reviewed and grey literature, clinical practice guidelines, stakeholder input, and other subject matter experts in consultation with the State DOH. The report should include: <ul style="list-style-type: none"> ○ 1) high-level statements including a tentative statement of the proposed denominator and numerator, ○ 2) measure justification form (provided by the State DOH), ○ 3) a review of the ability to use the existing measures with the proposed measures without change, adaption, or as a model for development (comparison framework), and ○ 4) scientific evidence on the measure using the National Quality forum evidence criterion. 		
<p><i>Convene expert panel and summary findings report of the panel</i></p> <ul style="list-style-type: none"> • Convene a panel comprised of representatives from the State DOH and other State agencies (e.g. OMH, OASAS, OPWDD), including quality measurement and subject matter experts, to review the Contractor's measure concept, proposed measure, evaluation of existing measures, and scientific evidence. • Assist with meeting logistics and develop relevant materials for review. • Provide a report summarizing the key findings of the panel. 		10%
<p><i>New NYS Measure Development and Calculation</i></p> <ul style="list-style-type: none"> • Write technical specifications for the data collection and calculation of the measure and submit to the State DOH with Risk Adjustment Methodology as necessary. • Construct a comprehensive data protocol and develop source code for any administrative measures, and develop a flowchart documenting key decision points. • Develop a workplan for testing the measures for State DOH approval, implement the workplan, analyze test results and refine measure specifications as needed, and report the results to the State DOH. • Construct a data protocol and source code for any administrative measures and submit to the State DOH. 	D.4 1) 7 k-l	25%

<ul style="list-style-type: none"> • Develop a flowchart for documenting key decisions in the technical specifications, reports summarizing measure specifications, source code, and baseline data with quality measure results according to the State DOH specification and submit to the State DOH. • Develop a workplan for testing the measure with data sources and specific area for analysis and submit to the State DOH. • Implement the workplan, analyze the test results, and refine measure specifications. • Report the results of the initial analysis to the State DOH in a summary report. 		
<p><i>Solicit public comments</i></p> <ul style="list-style-type: none"> • Prepare documentation to solicit public comment on measure. • Respond to public comment and report communications to the State DOH in summary report. • Facilitate any revisions from the State DOH to the measure. 		10%
<p><i>First year analysis</i></p> <ul style="list-style-type: none"> • For first year measures, provide the State DOH with analysis plans, report formats, and draft reports for approval. • Follow the CMS EQR calculation for non-QAPI performance measures. • Analyze and present results to the State DOH and stakeholders in approximately 3-5 meetings. 		20%
<p><i>Ongoing review</i></p> <ul style="list-style-type: none"> • Review measure performance through evaluation of the usefulness and ultimately providing recommendations to the State DOH for continuation, refinement, or retirement. • Review measure performance on an ongoing basis, evaluate the usefulness and provide recommendations on continuation, refinement or retirement of measures to the State DOH, and document the continuing evaluation/maintenance of measures in an annual report to the State DOH. • Document these findings in a formal report to the State DOH. 	D.4.1) 7 o	15%
4.1.1.8 Conduct Studies on Healthcare Quality		
<p><i>Study Proposal</i></p> <ul style="list-style-type: none"> • Work with the State DOH to identify the topic and scope of the study. • Develop proposal with sound methodology for the topic selected by the State DOH. • Develop a study design for State DOH approval according to the specifications in the RFP scope of work. 	D.4.8.a D.4.8.b D.4.8.c D.4.8.d	10%
<p><i>Data Analysis Plan</i></p> <ul style="list-style-type: none"> • Prepare data analysis plan outlining approach to analysis and proposed table/chart displays and submit to State DOH for approval. 	D.4.8.f	10%

<ul style="list-style-type: none"> <i>Data Collection Tool and Instructions</i> Prepare electronic data collection tool and instructions and submit to State DOH for approval. 		10%
<ul style="list-style-type: none"> <i>Complete Reviewer Training</i> Train reviewers on data collection tool and instructions. 	D.4.8.e	5%
<ul style="list-style-type: none"> <i>Complete Data Collection</i> Submit requests to MCOs to provide data or medical records. Collect data and input to data collection tool. 	D.4.8.e	35%
<ul style="list-style-type: none"> <i>Complete Analysis</i> Analyze data. 	D.4.8.f	10%
<ul style="list-style-type: none"> <i>Final Report</i> Prepare draft technical report and submit to the State DOH for approval. Incorporate State DOH comments and submit final report. 	D.4.8.f D.4.8.h	15%
<ul style="list-style-type: none"> <i>Present Findings</i> Present findings in a meeting to MCO medical and quality directors and send final report to MCOs. 	D.4.8.g	5%
4.1.1.9 Annual EQR Technical Reports		
<ul style="list-style-type: none"> <i>Report Outline Submitted</i> Work with the State DOH to determine report format and specific data sets to be included. Prepare outline of report and submit to State DOH for approval. 		10%
<ul style="list-style-type: none"> <i>Draft Report Template Submitted</i> Produce the report in a manner and template approved by the State DOH. Prepare report template, including data presentation and plan-specific summaries. 	D.4.9.a	10%
<ul style="list-style-type: none"> <i>Draft Report Submitted</i> Include information specified in the RFP scope of work. Populate data tables using data compiled from EQR activities. Address EQR activities for all Medicaid MCOs. Include individual plan reports and a statewide summary with State-level recommendations for performance improvement Include statewide benchmarks and trends over time. Calculate ratios or other descriptive indicators. Include findings from MCO compliance with State standards and any additional data and information requested by the State DOH. Include a section that addresses the State's Quality Strategy and determine whether any updates are necessary based on the results of the EQR. Prepare report narratives, including assessment of strengths and opportunities for improvement. Submit an outline of the proposed format to the State DOH and submit the draft and final reports according to the RFP scope of work. 	D.4.9.b D.4.9.c D.4.9.d D.4.9.e D.4.9.f D.4.9.g D.4.9.h	50%

<p><i>Final Report Submitted</i></p> <ul style="list-style-type: none"> • Complete any necessary revisions, per guidance from the State DOH • Submit final summary report to the State DOH 	D.4.9.h	20%
<p><i>Reports Distributed</i></p> <ul style="list-style-type: none"> • Distribute final reports to MCOs 		10%
4.1.1.10 Focus Groups		
<p><i>Sampling Protocol</i></p> <ul style="list-style-type: none"> • Work with the State DOH to identify focus group population and determine sampling methodology • Develop recruitment criteria. • Develop focus group guide/script in consultation with State DOH to answer study questions. • Manage the group. 	D.4.1) 10.a D.4.1)10.b	5%
<p><i>Script Development</i></p> <ul style="list-style-type: none"> • Develop focus group guide/script in consultation with the State DOH to answer study questions. 		10%
<p><i>Participant Recruitment</i></p> <ul style="list-style-type: none"> • Recruit participants for focus group sessions. 		20%
<p><i>Produce transcripts.</i></p> <ul style="list-style-type: none"> • Conduct focus group according to parameters agreed upon by the State DOH. • Record the interviews. 	D.4.1)10.c D.1.4)10.d	50%
<ul style="list-style-type: none"> • <i>Analyze the transcripts.</i> Prepare summary report of findings and submit to the State DOH for review. 	D.4.1)10.e	10%
<ul style="list-style-type: none"> • <i>Provide a report to the State DOH.</i> Revise draft report according to guidance from the State DOH, 	D.4.1)10.f	5%

ATTACHMENT D
Annual Volumes

Activity 1. External Quality Review Services

	Work Plan Activity (Estimated annual volume)	Unit Definition	Annual Volume
1)	Validation of PIPs (13 MMC, 12 HARP, 3 HIV SNP, 45 MLTC plans), twice each over contract	One plan PIP validation	29.6
2)	Validation of Performance Measures		
1	MCO Quality Data (up to 40 MCOs and 80 lines of business)	One summary finding report	1
2	Validation of Functional Assessment Data	One validation study	1
3)	Review of Compliance with Medicaid Regulations		
1	Provider Directory Survey	One survey administration	2
2a	Provider Access and Availability Survey – Primary Care/OB-GYN (Average of 2400 calls)	One survey administration	1
2b	Provider Access and Availability Survey – Behavioral Health (Average of 1000 calls)	One survey administration	1
3	Plan Member Services Survey (Average of 480 calls)	One survey administration	2
4	High-Volume Enrollee to Provider Ratio Survey (Average of 800 calls)	One survey administration	1
4)	Validating Network Adequacy (16 templates, 350 networks)	One network validation tool	4
5)	Validation of Encounter Data	One validation study	1
6)	Administration of Consumer Surveys		
1	CAHPS (31 adult CAHPS, 15 child CAHPS)	One survey administration	1
2	Experience of Care Surveys (500 per plan)	One survey administration	2
7)	Calculation of Performance Measures	1 Measure Development	1
8)	Conduct Studies on Healthcare Quality		
	Focused Clinical Study – MMC (600 records)	One study	1
	Conduct Focused Clinical Study – HARP (400 records)	One study	0.6
	Behavioral Health Focused Study – MLTC (400 records)	One study	0.4
9)	Annual Plan Technical Reports (13 MMC, 12 HARP, 3 HIV-SNP, 45 MLTC plans)	One set of annual reports	1
10)	Focus Groups (12 sessions over contract period)	One session	2.4

Activity 2. Office Based Surgery

	Work Plan Activity (Estimated annual volume)	Unit Definition	Annual Volume
1)	Quality of Care Review (average of 630 reviews per year)	One Review	630
2)	Adverse Event Reporting form and Dashboard		
1	Conduct assessment of business requirements and receive approval for transition plan	One-time cost	N/A
2	Complete activities required for transition of the Adverse Event Reporting form and Dashboard	One-time cost	N/A
3	Maintenance and Support Fee	Recurring monthly cost	12
4	Help desk Fee	Recurring monthly cost	12
3)	Hourly Rates for change requests will be based on the rates included in Special Studies and Improvement Projects. The titles that are applicable to this section include: Specialist Physician; Project Manager; Database Administrator; Computer Programmer; Data Analyst; and, Web Designer		

Staff Listing	Projected Annual Hours
Specialist Physician ("Specialized" means board certified in an area that DOH deems appropriate to the subject matter being supported)	100
Project Manager	80
Web Designer	40
Database Administrator	80
Computer Programmer	80
Data Analyst	24

Activity 3. Provider Network Data System

	Work Plan Activity (Estimated annual volume)	Unit Definition	Annual Volume
1)	Development of a data intake website	One-time cost	N/A
1	Development of data submission system within data intake website	One-time cost	N/A
2)	Development of data intake portal	One-time cost	N/A
1	Development of dashboard within intake portal	One-time cost	N/A
2	Development of a deficiency tracking system within intake portal	One-time cost	N/A
3	Development of API to share data	One-time cost	N/A
4)	Development of data extract and reporting system	One-time cost	N/A
1	Creation of monthly and quarterly data extract (7 reports)	One report	N/A
2	Creation of real-time extract (12 reports)	One report	N/A
6)	Development of file sharing area within reference library	One-time cost	N/A
7)	Validation of plan-submitted data files	Recurring monthly cost	12
8)	Maintenance and Support Fee (systems support, data correction, real-time data refresh, technical support, provision of analytics)	Recurring monthly cost	12
9)	Hourly Rates for change requests will be based on the rates included in Special Studies and Improvement Projects. The titles that are applicable to this section include: Project Manager, Database Administrator; Computer Programmer; Data Analyst; and, Web Designer		

Staff Listing	Projected Annual Hours
Project Manager	80
Web Designer	40
Database Administrator	80
Computer Programmer	120
Data Analyst	24

Activity 4. Sepsis Care Improvement Initiative

	Work Plan Activity (Estimated annual volume)	Unit Definition	Annual Volume
1)	Development of a web-based data collection and submission portal	One-time cost	N/A
2)	Development of a public-facing Sepsis Initiative webpage with secure login	One-time cost	N/A
3)	Development and distribution of reports to hospitals	One report	4
4)	Quarterly validation and correction of hospital performance data	One final report	4
5)	Maintenance and support fee (Sepsis Initiative landing page, ongoing technical assistance to hospitals, liaising between DOH and hospitals, data correction)	Monthly cost	12
6)	Organizing and participating in bi-annual hospital conference call	One meeting	1
7)	Hourly Rates for change requests will be based on the rates included in Special Studies and Improvement Projects. The titles that are applicable to this section include: Project Manager, Database Administrator; Computer Programmer; Data Analyst; and, Web Designer		

Staff Listing	Projected Annual Hours
Project Manager	80
Web Designer	24
Database Administrator	80
Computer Programmer	80
Data Analyst	40

Activity 5. State Health Profiles: Hospitals, Nursing Homes, Home Care, Hospice and Adult Care Facilities

	Work Plan Activity (Estimated annual volume)	Unit Definition	Annual Volume
1)	Development and implementation of a public facing website	One-time cost	N/A
2)	Development and implementation of architecture for data sharing across multiple applications	One-time cost	N/A
3)	Data Updates (Nursing Home and Adult Care facilities)	Recurring Monthly Cost	12
4)	Data Updates (Hospital and Home Care facilities)	Recurring Quarterly Cost	4
5)	Help desk fee	Recurring Monthly Cost	4
6)	Maintenance and Support fee	Recurring Monthly Cost	12
7)	Hourly Rates for change requests will be based on the rates included in Special Studies and Improvement Projects. The titles that are applicable to this section include: Project Manager, Database Administrator; Computer Programmer; Data Analyst; and, Web Designer		

Staff Listing	Projected Annual Hours
Project Manager	80
Web Designer	40
Database Administrator	80
Computer Programmer	120
Data Analyst	24

Hourly Personnel Rates

Hourly staff rates are requested for Special Studies, quality assistance, and change requests. List the titles and composite hourly rates for each type of staff person who will work on these projects. Personnel types should fit into the existing categories. Do not add additional titles.

The composite hourly rates described must be inclusive of all costs, including salaries, fringe benefits, administrative costs, overhead, travel, presentation costs, and profit. These composite hourly rates will apply for the entire contract period. Staff may be required to be onsite at DOH locations in and around Albany, NY.

Staff Listing	MIS-C	Centering Pregnancy	Doula Surveys
Registered Nurse / Nurse Practitioner	1440	350	-
General Physician	720	176	-
Specialist Physician ("Specialized" means board certified in an area that DOH deems appropriate to the subject matter being supported)	-	-	-
Physician Assistant	-	-	-
Psychologist	-	-	-
Nurse Case Manager	-	-	-
Medical Records Coder	-	-	-
Project Manager	720	176	90
Secretarial / Clerical Staff	-	-	80
Web Designer	-	-	-
Information Technology Security Analyst	-	-	-
ETL Developer	-	-	-
Database Administrator	-	-	-
Systems Administrator	-	-	-
Computer Programmer	180	-	-
Statistician	-	-	-
Data Analyst	540	100	-
Researcher	-	-	-
Technical Writer	-	50	-

ATTACHMENT E
TRANSMITTAL FORM

Medicaid External Quality Review and Other Activities in New York State

RFP #20062

Bidder Name: _____

Bidder Address: _____

NYS Vendor ID Number: _____ DUNS #: _____

Type of Legal Business Entity: _____

Contact Person Information:

Name: _____

Title: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Designation as Qualified Organization Certification (Check only one):

- I certify that the above-named bidder is designated by the Center for Medicaid and Medicare Services (CMS) as a Medicare Quality Improvement Organization (QIO) as of August 19, 2021; **OR**
- I certify that the above-named bidder is on the list of QIO-Like organizations as of August 19, 2021.

Conflict of Interest Certification (Check only one):

- I certify that there are business relationships and/or ownership interests for the above-named bidder that may represent a conflict of interest for the organization as bidder. Attached to this letter is a description of how the potential conflict of interest and/or disclosure of confidential information relating to this contract will be avoided and the bidder's knowledge and full compliance with the NYS Public Officer's Law, as amended, including but not limited to, Sections 73 and 74; **OR**
- I certify that no conflict(s) of interest exist for the above-named bidder.

Subcontractor Certification (Check only one):

- I certify that the proposal submitted by the above-named bidder proposes to utilize the services of a subcontractor(s). Attached to this Transmittal Form is a list of subcontractors and a subcontractor summary for each; **OR**
- I certify that the proposal submitted by the above-named bidder does not propose to utilize the services of any subcontractor.

Conditions of Independence

- I certify that at the time of bid, that the Bidder and any proposed subcontractors meet the conditions for independence as defined in federal regulation at 42 CFR 438.354(c).

By signing below, the bidder attests to all of the following:

I certify that the bidder accepts the contract terms and conditions contained in this RFP including any exhibits and attachments.

I certify that the bidder has received and acknowledged all Department amendments to the RFP, as may be amended.

I certify that the bidder is prepared, if requested by the Department, to present evidence of legal authority to do business in New York State, subject to the sole satisfaction of the Department.

I certify that the bidder (i) does not qualify its proposal, or include any exceptions from the RFP and (ii) acknowledges that should any alternative proposals or extraneous terms be submitted with the proposal, such alternate proposals or extraneous terms will not be evaluated by the Department.

I certify that the proposal of the bidder will remain valid for a minimum of 365 calendar days from the closing date for submission of proposals.

Signature of Individual Authorized to Bind the Above Named Organization In a Contract with NYS:

(Signature)

Date: _____

Print Name: _____

Title _____

Address: _____

Phone: _____

Fax: _____

Email: _____