

**MEDICAID DISEASE AND CARE MANAGEMENT
DEMONSTRATION PROGRAMS RFP
Questions & Answers - Set 3
May 6, 2005**

The responses to questions included herein are the official responses by the State to questions posed by potential bidders and are hereby incorporated into the Medicaid Request for Proposals (RFP) issued March 21, 2005. In the event of any conflict between the RFP and these responses, the requirements or information contained in these responses will prevail.

PART I

1. Why won't staff at DOH talk to me on the phone and answer my questions directly? Why do they insist I do everything through email, and make me wait for "official" answers to my questions?

A. Proposals for the Medicaid Disease and Care Management Demonstration Programs are being solicited through a Request for Proposals process, consistent with NYS legislation. This is a competitive process, and therefore all potential bidders must be provided equal access to the exact same information. Official Questions and Answers are being made available as soon as reasonably possible based on the amount of questions received.

2. I missed the deadline for the Letter of Intent. Will the DOH consider extending the deadline for submitting the letter, and the opportunity to get the aggregated Medicaid data? (PART III-3)

A. Yes, in order to assure maximum participation, the deadline for submission of the Letter of Intent has been extended to **May 24, 2005**. If you submit a Letter of Intent on company letterhead, signed by an authorized representative, the data will be sent to the contact person identified in the letter of intent. See the "Official Modifications" section for details.

3. Will this project require the awardee to be subject to the federal Medicaid prepaid ambulatory health plan (PAHP) regulations (42 CFR 438.2) and, if so, how will this affect the project?

A. The CMD does not relieve the bidder of any regulatory requirements, nor impose any new regulatory requirements. If the awardee is operating under certain Medicaid regulations, those regulations will still apply.

4. In Care Management Populations: it states that “Medicaid recipients will be excluded from the intervention group if they are domiciled or residing in a developmental center, mental health institution or hospice.” What is the minimum period post-discharge from the excluded group before the client becomes an eligible member of the pool? (PART I-5)

A. DOH may consider a contractor's submission of population definition criteria for Medicaid recipients discharged from the above referenced institutions (excluding hospice). Any Medicaid recipient receiving case management services, post-discharge, will not be eligible for enrollment in a CMD.

5. Would a CMD for clients who are enrolled in an ACT (Aggressive Community Treatment) program be ineligible for CMD services?

A. A proposal to provide CMD to recipients that are already in a case management program identified by the Medicaid State Plan would not be appropriate. See Questions and Answers Set 2, questions # 11-13.

6. Will Medicaid assist us in tracking patients who move during the 2 years of the project and at the end of the project?

A. See Questions and Answers Set 2, question # 47.

PART II

7. We are a comprehensive hemophilia treatment center provided by a school of medicine of a large hospital. Our approach to care is a disease management, multi-disciplinary model. We are not sure we are eligible because we are part of an institution. We also are partially supported by federal grants. Can we bid?

A. There are no apparent reasons why the bidder could not apply. Please see Questions and Answers Set 1, question # 19 and Questions and Answers Set 2, question # 21. However, note that a CMD cannot be an add-on to or an expansion of other current proposal(s) or care management programs.

8. TP-1: question # 4 requests program evaluation and documentation of cost savings including a copy of final reports. Our program does not have documentation of cost savings. Does this lack of documentation fail to meet the minimum requirement and therefore not qualified to submit a proposal? (PART II-3)

A. No, the minimum qualification to bid does not include documentation of cost savings; the bidder is only required to describe their previous experience which meets the minimum qualifications in PART II-3. However, in evaluating the bidder's corporate experience, (PART II-5, # 7), documented cost savings achieved by the

bidder is requested. If no documentation of savings is available, the bidder could be evaluated to be less effective than another bidder who is able to provide such evidence. Final reports or any other documents of program evaluation should be submitted with the bidder's proposal. See Questions and Answers Set 2, question #54.

9. In as much as there has not previously been a mechanism to manage asthmatics in the home, how do we complete for TP-1: Summary of Experience and References?

A. Refer to PART II-5, 7. Bidders are required to provide TP-1 forms with detailed information and references for any current or previous clients for whom care or disease management services were provided. For a new type of care management approach, it is expected that no references would be available for completing that specific activity, but other references regarding the bidders work should be provided.

10. Would Lombardi and AIDS Home Care Programs be examples of care management programs? Would evaluations for DSS for housekeepers, homemakers also be examples?

A. The Lombardi and AIDS Home Care Programs, evaluations for DSS for housekeeper and homemaker may be used by the bidder as examples of care management programs for the purposes of reporting previous experience.

11. Summary of experience and references: TP-1 form, for the 3 references, can you use a subcontractor as a reference? PART II-5

A. No, not if the same subcontractor is being proposed for this bid.

12. We have pilot data on several small programs targeting adult patients with asthma in East Harlem which are considering submitting for funding through this mechanism. Is the scope of the project too small for this RFA. Can you clarify for us?

A. DOH is particularly interested in smaller, innovative approaches to care and disease management for the target population. However, a CMD cannot be an add-on to or an expansion of other current proposal(s) or care management programs. See PART II-8-9. Refer to Questions and Answers Set I, questions # 19, 32, 35. Also, note this is a competitive RFP procurement, not and RFA, see Questions and Answers Set 2, question # 2.

13. Will DOH provide the contractor with patient addresses to do endorsed mailings, or will DOH do the mailings for the vendor without providing us patient information, telling patients they can contact us directly?

A. The contractor will be responsible to send all approved mailings to enrollees. The DOH will provide the contractor with the most current contact information for each enrollee. However, the bidder will need to have procedures and strategies in place to locate enrollees when addresses or telephone numbers prove not to be accurate.

14. Will self reported data be acceptable for outcomes evaluation related to quality of life and health status?

A. Yes; however the bidder's proposal must include the methodology that will be used to confirm the clinical health outcomes that are reported by the enrollees. Also, the bidder cannot rely only on self reported health outcomes as the only type of clinical outcomes measure that will be utilized. Refer to PART II-15, section 8.c., and Questions and Answers Set 1, questions # 43 and 44.

15. Can you tell us specifically what data will be needed during and after the RFP? I would like to program a database specifically for this RFP.

A. Refer to PART II-8, PART II-15-17 and Questions and Answers Set 1 question # 83 and Questions and Answers Set 2 question # 44.

16. Can a bidder define the enrollees as Medicaid fee-for-service clients who have had at least one visit to a New York City Health and Hospitals Corporation facility in the last 12 months? (PART II-10).

A. This could not be the sole specification for identifying potential intervention population. However, this criteria could be included as one of a set of criteria for defining the potential intervention population.

17. Clinical performance measures are a key aspect of the CMD Evaluation Strategy; will control group clients be monitored on the same schedule as enrollees? Will there be an opportunity to perform a qualitative evaluation (e.g., satisfaction with services, quality of life changes, etc.) with the controls? (PART II-15)

A. Clinical performance measures will be measured for the control group where applicable. See Questions and Answers Set 1, question # 91. DOH will apply clinical performance measures to the control group where data may be accumulated from Medicaid healthcare claims.

18. Please confirm the total number of staff and staff titles required for submission of Form TP-3/Resumes. The listing on page II-20 includes "Contract Manager" and "Medical Director" -which define exact positions and titles. The additional headings in this list include "Care Manager Staffing" and "Staff Training and Quality Management," which seem more like areas of responsibility without defining a specific role. Are vendors expected to propose staff (expressed in a TP-3 form) for these headings ("Care manager staffing" and "Staff training and quality management")? (PART II-19, PART II-21)

A. At a minimum the bidder must provide TP-3 forms and references for the Contract Manager and the Medical Director. DOH anticipates that bidders will provide additional TP-3 forms and references for personnel that will be utilized for care management staffing, particularly supervisory personnel. Additionally, the bidder must meet all the bid requirements in PART II-20-21 for Care Manager Staffing and Staff and Quality Management.

19. Please clarify. How do status reports differ from monthly, quarterly or annual reports?

A. PART II page 21, #4, "Communication with DOH", provides a detailed description of the status reporting requirements for bidders.

20. Does the phase down plan end on last month of operations (month 24) or when no longer receiving PMPM rate? Or does it extend past 24 months and do we receive payment if it does? (PART II-21)

A. Refer to Questions and Answers Set 1 question # 49.

21. We understand the formula used to determine the PMPM. However, we expect, during the first four months to hire and train staff so that they are ready to go beginning with month 5. It was my understanding (from the bidders' conference) that we should NOT commence enrollment until after the four-month implementation period. Obviously, the number of enrollees will start off small and will grow incrementally. How will staff salaries (costs of the program) be supported during the "enrollment ramp-up" period? (attachment 7)

A. The contractor may spend funds received from the one time implementation phase payment for staff salaries during the enrollment ramp-up period. The contractor may also phase in staffing as needed after the enrollment ramp-up period is completed. Please refer to PART-II-25 c.d.

PART III

22. If a recipient has a co-morbidity, are the total expenditures split between the two diseases in the aggregated Medicaid data or is the total for the recipient in each disease category? If the answer is that it is not split, then is there a formula to allocate the expenditures? (PART III-3-4)

A. The aggregate Medicaid data is the total costs for all recipients that meet the criteria included in Attachment 2. If a recipient has two diseases, their utilization data would be included in both sets of data (i.e. asthma and mental health).

ATTACHMENTS

23. Is there a more detailed subset of the (COS) breakouts of the aggregate FFS Medicaid population data available?

A. No. The aggregate Medicaid data refers directly to the disease-specific populations found in Attachment 2 of the RFP. No additional aggregate Medicaid data is available.

24. Questions and Answers Set 1, question # 84 indicates that "recipient specific" Medicaid data will not be provided by DOH." Please confirm that this applies to the proposal/bid phase only. Will selected vendors have access to such data as necessary to conduct of their proposed CMD? (Attachment 2)

A. Yes, bidders will not receive recipient specific Medicaid data, but the contractors will be provided access to recipient specific data consistent with HIPAA, IRB and DEAA requirements.

25. How do bidders obtain the list of patients to be included in their CMD? Is it possible to get the list of patients now with their associated hospitals or do we wait until the awards are made? (Attachment 4)

A. The contractor may only enroll recipients identified by the DOH through the selection process identified in Attachment 4. Only bidders who are awarded contracts following the evaluation process will be provided Medicaid data. See Questions and Answers Set 1, question # 81-82.

26. Functionally, once a patient is enrolled in the CMD, we can still forecast what this client would have cost Medicaid, should he/she have still been FFS/Medicaid eligible (e.g., track utilization). This would fulfill the research requirements of the contract and we would not have lost time and resources in recruiting and engaging a new enrollee. Is this scenario feasible for the State? (Attachment 5)

A. No.

27. If the enrollee loses Medicaid during the month in which service is provided, the CMD provider will not find out until after the end of the month billed. The CMD provider will have provided services in good faith and will be providing service into the next month before the provider receives a roster indicating nonpayment. That could be more than a month of service provision. Does the CMD provider receive a partial payment based on the date of ineligibility? Once notified, can the CMD notify enrollee and discharge immediately or are their discharge requirements? (Attachment 7)

A. There will be no partial payments. However, a reconciliation of payments will be completed periodically. Please review question # 28 of this set. There are no specific requirements regarding discharge for a CMD. Please see Questions and Answers Set 1 question # 8 and Questions and Answers Set 2 question # 6.

28. Some clients come on and off the Medicaid rolls; will there be any grace period before a client becomes disenrolled from the CMD? (Attachment 7)

A. There will be no grace period. A PMPM payment is triggered only on verification of Medicaid eligibility each month. See Question and Answers Set 1 question # 8.

GENERAL

29. Do you have information regarding language distribution by county?

A. No.

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 DEMONSTRATION PROGRAMS RFP
 Modifications - Set 3
 May 6, 2005**

The following are official modifications, which are hereby incorporated into the New York State Medicaid Disease and Care Management Demonstration Programs Request for Proposals (RFP), issued March 21, 2005. In the event of any conflict between the RFP and these modifications, the information contained in these modifications will prevail.

Section Page #	Specific Location	Current Language	Corrected Language (bold)
PART I-4	C.3	Because of limited funding and the interest of testing different models of CMDs, the maximum award for any individual CMD will be limited to one million, five hundred thousand dollars (\$1,500,000) per twenty-four (24) month contract awarded.	Because of limited funding and the interest of testing different models of CMDs, the maximum award for any individual CMD will be limited to two million dollars (\$2,000,000) per twenty-four (24) month contract awarded.
PART III-2	B.5	The Letter of Intent must be received by the Issuing Agency no later than April 26, 2005.	The Letter of Intent must be received by the Issuing Agency no later than May 24, 2005 .