MEDICAID DISEASE AND CARE MANAGEMENT
DEMONSTRATION PROGRAMS RFP
Questions & Answers - Set 4
May 17, 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. **Will the State consider extending the due date for proposals?**

   A. No, proposals are due by 3:00 p.m. on May 31, 2005.

2. **Can DOH estimate the percentage of enrollees who will become ineligible over the course of the 24-month demonstration based on historical profiles of similar patients who are in FFS Medicaid for six (6) months or more? (PART I-5)**

   A: An analysis of the chronic disease population in CY 2003, exhibited in Attachment 2 of the RFP, indicates that roughly 90% of the population remained eligible for the full twelve (12) months of the year. The remaining 10% of the population was eligible on an intermittent basis.

2. **We understand that all contracts will be for a period of twenty-four months (24) months in duration. Is it possible to apply for one-year only; i.e., apply later in the year to implement a program in the 13th month of the contract period? (PART I-5)**

   A. There is only one competitive procurement period for the CMD RFP. All contracts for selected bidders are expected to be for a period of 24 months.

3. **What is the expected month to month rate of turnover for the CMD population? (Turnover due to loss of Medicaid status, opting out, etc.)**

   A. The DOH does not have any information on the monthly turnover rate for a CMD. Please see Question and Answer Set 4, #1, above.

4. **Are there a minimum number of enrollees that DOH expects? (PART I-5)**

   A. No. See Questions and Answers Set 1, question # 35.

5. **Some HIV patients on FFS Medicaid or other programs (i.e., ADAP Plus) that supplement Medicaid remain in the primary care system until they reach the Medicaid spend down threshold or when the client temporarily looses commercial insurance services. Would this client remain enrolled in the CMD?**

   A. Only Medicaid FFS eligible recipients can remain enrolled in the CMD.

6. **What interventions are not "direct" interventions (for the purpose of requiring an agreement by the recipient to participate in the CMD)? If a CMD provides interventions through an existing community physician or pharmacist that already treats the intervention enrollee, and for which the CMD may pay the provider, would that be considered a direct intervention? Is the recipient's original enrollment sufficient as an "agreement" to undertake a direct intervention? (PART I-6)**

   A. Working solely with the providers, and not having any direct interaction with the recipients, would not require written agreements from intervention enrollees regarding the CMD operations with the provider.

7. **Are the CMD projects funded entirely with State money, or is federal participation anticipated?**

   A. The CMD projects are funded by a state-only appropriation. There is a potential for some specific projects to be eligible, in limited circumstances, for matching federal funds.

PART II

8. **We are looking at an application with a Health Dept. as the prime contractor with a managed care organization and a local hospital as subcontractors and technical support. Can the coordination of care information on TP-1 reflect the experience of one of these subcontractors (i.e., the managed care organization's experience with the Medicaid SSI population)?**

   A. As the prime contractor, the health department would be required to submit TP-1 forms summarizing and detailing the health department's previous experience with the management and coordination of care to persons with chronic disease. In addition, each subcontractor would be required to submit TP-1 forms for at least three (3) business references that can demonstrate the subcontractor's prior or current experience with the specific function that they will be completing for the CMD. (PART II-6)

9. **We had approximately 1,200 Medicaid recipients in our county for all disease groups in 2003. We have about 1,800 Medicaid enrollees. With Medicare dual eligibles, we have 3,700. We note that CMDs that plan to include dual eligibles cannot do so until July, 2006. Is this a strong enough base of enrollees for which to file an RFP? (PART II-9)**

   A. It appears to be an adequate number of Medicaid enrollees to test a CMD. Refer to Question and Answers Set 1, question # 36.

10. **May a bidder bid on ESRD & CKD in the same region, because an ESRD is a continuum of certain levels of CKD. If we can, are we allowed to bid this on one set of documents?**

    A. A bidder may submit a single bid to address ESRD and CKD concurrently in the same region for the same patients. A bidder may not submit two different bids for treatment of two sets of patients, because each bidder is limited to one bid. Refer to Questions and Answers Set 1, question # 19.

11. **In reviewing the enrollment requirement, we believe that active enrollment should occur if, after the contractor sends the recipient a letter of enrollment that identifies the person as a potential intervention enrollee, the recipient does not call or write, within a reasonable time that they prefer not to participate. If no such communication is received from the recipient then the contractor may assume that the enrollee is an intervention enrollee for services and payment. Please confirm. (PART II-11)**

    A. This description would not appear to be an adequate definition of an active intervention enrollee for the purposes of payment. As part of the technical proposal response, the bidder is required to submit their proposed definition for an active intervention enrollee. Each selected bidder's definition will be subject to DOH review and approval.

12. **In the Questions and Answers Set 1 question # 26, DOH stated that a local district can provide endorsement of the private sector bidder who would serve as the prime bidder. (In relation to PART II-2) We are a community organization acting as the prime contractor with a second community agency as a subcontractor; may we submit endorsements from the counties and state agencies in which we provide services (and which are within the intended CMD region)? These would be in addition to those we list among our 3 required reference clients. If we can include such endorsements in what format should we submit these - letters of support etc.?**

    A. Yes, you may include letters of endorsement or support from other community organizations which are familiar with your activities. The letter should be on the official letterhead of the agency with the signature of an official authorized to provide such an endorsement. However, the evaluation of the bidders will be based on the actual references submitted on Form TP-1. If the organizations are willing to be submitted as a reference, this would be more effective in relation to the bid evaluation process.

13. **As we interpret CMD RFP Questions and Answers Set 2 Question # 26: Are we correct in assuming that <u>each individual</u> hospital in the Corporation can submit a bid <u>but</u> it must be a stand alone bid utilizing the organizational structure and fiscal management <u>of the hospital and not the corporate parent</u>? In effect, each of our hospitals would be competing with each other in a larger**

Pool of competing cohorts as prime contractors utilizing their individual corporate organization. Is this correct?

A. No, your interpretation is not correct. Only a single bid may be submitted from a corporation. There are two options for a network of hospitals under a single corporate management to submit bids:

a. A bid could be submitted by the corporate parent to operate the same CMD in one or more of the hospitals which under the financial and management direction of that corporation. All locations of the CMD sites must be within the same region, and **all locations must provide the same CMD services**.

b. A single hospital within the network may submit a bid to operate a CMD under its own management. (However multiple bids cannot be accepted from multiple hospitals which are under the same corporate organization.)

14. Are TP-1 forms required for Medicaid funded service contracts that aren't disease or care management programs such as DOH and OMH fee for service clinics or case management and ACT team services provided for mental health service recipients and licensed by OMH?

A. This requirement was previously clarified to confirm that references need only be submitted for Medicaid contracts related to care or disease management. This is an official modification of the RFP. See the "Official Modifications" section of Questions and Answers Set 1.

15. Will DOH be contacting the references listed in the TP-1 or should the bidder seek materials from the identified reference to enclose with the TP-1 form?

A. The bidder should not provide materials from identified referenced clients other than the required TP-1 and EO127 forms. DOH will contact all references.

16. In the official modifications included in questions and answers set one DOH described the modifications to PART II-7 as follows, "The DOH shall review the amount of effort provided by the prime contractor and proposed subcontractor(s). To be approved, a prime contractor must be responsible for meeting all of the contract provisions but also must provide at least 30% of the total effort'. Is there a maximum effort the prime contractor is allowed - can it be up to 100%?

A. If the prime contractor is utilizing a subcontractor(s) to meet contract provisions, the prime contractor which submits the bid must provide <u>at least</u> 30% of the effort for completing the CMD. They may provide more than 30% of the effort if appropriate. If there is no subcontractor, the bidder would of course provide 100% of the effort.

17. **Can State DOH send mailings to disease management participants? If so, how frequently? (One-time only, quarterly, monthly?) (PART II-14)**

    A. The contractor will be responsible to send all DOH approved mailings to enrollees. See Questions and Answers Set 3, question # 13.

18. **Can DOH clarify the meaning of the contract performance standard 10.c: provision of urgent and emergent enrollee care management services based on DOH approved policies and procedures"? Will DOH define urgent and emergent care management services? (PART II-17)**

    A. See Questions and Answers Set 2 question # 31.

19. **The RFP currently requires that annual reports be provided no later than 30 days following the close of the reporting period. To accommodate for the lag in medical claims submissions and the need to capture these in accurate program evaluation, will the State consider adjusting this requirement to 90 days? (PART II-17)**

    A. DOH expects bidders to be monitoring and evaluating the utilization and health outcomes of the CMD on a continual basis during the term of the contract. The annual report will be a compilation of these outcomes. However to assure adequate time, the DOH will extend the due date of the annual report to 60 days after the close of the reporting period. This is an official modification of the RFP.

20. **We question the need for the IRB and informed consent. The provision of disease and care management services is well recognized and accepted under Medicaid and Medicare. These services are recognized and have been provided for many years by health plans. Finally, the HIPAA Privacy Rule does not characterize these services as "research" but rather as "health care operations" of the health plan. Please describe why you feel that the contractor is performing a research project by providing these services. (PART II-22)**

    A. The DOH. Medicaid and IRB program requirements are necessary, have been confirmed as necessary requirements for CMD operation, and must be completed by the selected bidder.

PART III

21. **Our company provides disease management services for persons with diseases that are not included in the data set. These are: Multiple Sclerosis, Hemophilia, Crohn's Disease, Hepatitis C, Rheumatoid Arthritis, Primary Immune Deficiencies. Is there any data available regarding these conditions? (PART III-3)**

    A. If a contractor were selected to provide CMD services for one or all of these complex conditions, Medicaid data would be available to the contractor based on

contractor-selected, DOH-approved, criteria. However, Medicaid aggregate data is not available pre-bid for these diseases.

22. What type of disease hierarchy, if any, was used for preparing the data list we received? Can we be assured that those participants with more than one qualifying disease are only counted once in the data? (PART III-3)

A. A disease hierarchy was not used to prepare the aggregate Medicaid data. The recipient count for the chronic diseases is duplicative. See Questions and Answers Set 3, question # 22.

23. We received a CD with data; however it included both Medicaid and Medicare eligibles, which did not allow us to interpret the data without dual eligible data records. Is this data available excluding Medicare Dual Eligibles? (PART III-3)

A. No, the Medicaid aggregate data is not available with Medicare dual eligibles excluded. Refer to Attachment 2 which provides two sets of aggregate data tables, one including dual enrollees, and one based on Medicaid only recipient.

24. Is there a page limit for the technical proposal? (PART III-4)

A. Yes, the DOH requires brief, concise bids. Bidders are required to follow the standards established in Questions and Answers Set 1 question # 59. Failure to follow such guidelines may result in a reduction in evaluation score.

25. The State's proposed evaluation criteria based on total proposed CMD price does not accommodate the extreme importance of overall CMD enrollment size a variable which is left open to bidders. The total price of any CMD is extremely dependent upon the size of the CMD itself. Consider the following example - CMD #1 proposes a program size of 1000 patients, at a total price of $1M. CMD #2 proposes a program size of 10 patients, at a total price of $100k. Assuming the two bids were of equal technical score, the current evaluation criteria would award a 30-3 scoring advantage to CMD #2, despite the fact that CMD#2 is vastly more expensive to the state than CMD#1 on a per member per month basis. Would the state consider adjusting its price evaluation methodology to compare bids on a level playing field by evaluating per member per month pricing? PART III-11

26. No. Such an approach would disadvantage models of care management which provide more intense types of intervention, or treat more complex chronic diseases, which would be inconsistent with the legislative intent. Based on the type of procurement and the objectives of the Department, the pricing evaluation will be based on the methodology defined in the RFP.

Attachments

27. Will Medicaid data include beneficiary phone numbers? (Attachment 4)

A. No. DOH will provide the most current address on file for each prospective CMD enrollee. Obtaining telephone numbers will be the responsibility of the contractor.

28. If an enrolled participant cannot be located and/or has not responded to any contact, is the contractor permitted to "disenroll" the enrolled participant? If yes, what would be the accepted procedure to disenroll?

A. If contractor has made a good faith effort to contact prospective CMD enrollee and has received no reply to repeated attempts at contact, then the contractor may consider said prospect an opt-out. There are no specific disenrollment or discharge procedures defined by the DOH.

29. How often will the data for replenishing enrollment be provided? (Attachment 4)

A. New potential intervention group enrollees will be provided by the DOH to CMDs as necessary, but no more frequently than quarterly.

30. How often will the enrolled participant Medicaid claims data be provided? (Attachment 4)

A. The CMDs will be provided updated data monthly on utilization by their intervention enrollees, which will included claims received as of that date. See Questions and Answers Set 1 question # 79.

31. Is DOH intending applicants to propose the programmatic and clinical measures cited in Attachments 5 and 6? Is bid response requirement to organize the measures as presented in Attachments 5 and 6 within domains (i.e. programmatic, clinical, etc.) and not to specifically propose new evaluation questions? (PART II-15)

A. Refer to Questions and Answers Set 1, question # 86. The bidder must provide a list of evaluative questions proposed to measure clinical and cost effectiveness. These measures will be part of the final CMD program evaluation.

32. Will we receive detail on prescription dosages and lab results?

A. The pharmacy data includes the 11 digit NDC claim which provides the drug specific dosage form and strength. Days supply data, as entered by the pharmacist, is also included on the pharmacy claim. Laboratory data is not available on the MMIS claim file, and is not collected by the DOH.

33. Can the State provide data for its program to indicate current performance relative to these clinical measures? (Attachment 6)

A. No, clinical performance data is not available.

34. Are HbA1c kits currently paid for by the NYS Medicaid program? Is current HbA1c lab data available for analysis by selected bidders? (Attachment 6)

A. HbA1c testing is included in the laboratory test reimbursement rate. Laboratory test report values are not available on the MMIS claim file, and are not collected by DOH.

General

35. Are incentive payments to medical providers, similar to managed care's per member per month (PMPM) incentives, allowable for a participant's medical "home" provider? If yes, would any kind of subcontract be required? This might be difficult, as we will potentially be working with a large number of providers.

A. A bidder may propose to make incentive payments to providers to encourage their participation in the CMD. However the proposal would need to provide adequate protections and accountability to assure that the contractor has sufficient oversight and accountability for such payments. Any such payments must be based on consistency with Medicaid rules, regulations and policies, and included in the total cost bid for the CMD.

36. The RFP only requests an example of the monthly report format to be provided by the contractor. Is the bidder also required to provide examples of the quarterly report format to be used for the CMD? (Part II-17)

A: Yes, the bidder should provide examples of both the monthly and quarterly report format they will be using for the CMD. This is an official modification of the RFP. See the “Official Modifications” section for details.

MEDICAID DISEASE AND CARE MANAGEMENT
DEMONSTRATION PROGRAMS RFP
Modifications - Set 4
May 17, 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 II-17	**B.3.e.9.c)**	Annual reports are due to the Department no later than thirty (30) calendar days following the close of the reporting period.	Annual reports are due to the Department no later than ~~thirty (30)~~ **sixty (60)** calendar days following the close of the reporting period.
PART II-17	**B.3.e.9. Bid Response Require-ments.c)**	Provide examples of proposed monthly report formats to be used.	Provide examples of proposed monthly **and quarterly** report formats to be used.