

**NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS**

A Request for Proposal for

**PROGRAM EVALUATION OF SECTION 1115
DEMONSTRATION PROGRAMS:**

**PARTNERSHIP PLAN/FAMILY PLANNING EXPANSION;
AND
FEDERAL-STATE HEALTH REFORM PARTNERSHIP**

RFP No.
0704051116

Proposal Due Date: February 22, 2008

New York State
Department of Health
Erastus Corning II Tower
The Governor Nelson A. Rockefeller
Empire State Plaza
Albany, NY 12237

Schedule of Key Events

RFP Issued	October 22, 2007
Letter of Interest to Bid Due (optional)	November 12, 2007
Written Questions Due	November 30, 2007
Registration for Bidders Conference Required by	November 30, 2007
Bidders Conference 10:30AM – 1:00PM Concourse Meeting Room #4, Empire State Plaza	December 13, 2007
Follow-up Questions Due	December 21, 2007
Response to Written Questions and Questions Received at Bidders Conference	January 16, 2008
Proposal Due Date	February 22, 2008
Contractor Selection	April 18, 2008
Contract Start Date (Estimated)	July 21, 2008

Department of Health Contact Information
Vida Wehren
NYS Department of Health
Office of Health Insurance Programs
Empire State Plaza
Corning Tower, Room 1927
Albany, NY 12237
Phone: (518) 473-0122
FAX: (518) 474-5886
e-mail: vlw02@health.state.ny.us

Contacts Pursuant to State Finance Law §§ 139-j and 139-k

DESIGNATED CONTACTS:

Pursuant to State Finance Law §§ 139-j and 139-k, the Department of Health identifies the following designated contacts to whom all communications attempting to influence this procurement must be made:

Kathleen Shure

Karen Kalaijian

Vida Wehren

Permissible Subject Matter Contacts:

Pursuant to State Finance Law § 139-j(3)(a), the Department of Health also identifies the following allowable contacts for communications related to the following subjects:

RFP Release Date: October 22, 2007

Submission of written proposals or bids:

Vida Wehren

Submission of Written Questions:

Vida Wehren

Participation in the Pre-Bid Conference:

Vida Wehren

Debriefings:

Vida Wehren

Negotiation of Contract Terms after Award:

Vida Wehren

For further information regarding these statutory provisions, see the Lobbying Statute summary in Section E, 10 of this solicitation.

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A. INTRODUCTION

1. General Information for Prospective Offerors

This Request for Proposals (RFP) is issued by the New York State Department of Health (DOH). The DOH is responsible for the requirements specified herein and for the evaluation of all proposals. This RFP is to secure consultant services for separate evaluations of each of New York State's Section 1115 Demonstration Programs – the Partnership Plan/Family Planning Expansion and the Federal-State Health Reform Partnership (F-SHRP).

The New York State Department of Health is the single state agency for administration of the New York State Medicaid program. Within DOH, the Office of Health Insurance Programs (OHIP) has responsibility for oversight of Medicaid and the Medicaid managed care programs described in this RFP. OHIP is also responsible for implementing the Terms and Conditions of the two 1115 Demonstration Programs and for working with other parts of the DOH to ensure that activities required under the waivers are implemented.

This RFP addresses two major tasks: (1) evaluation of the Partnership Plan/Family Planning Expansion Section 1115 Demonstration; and, (2) evaluation of the Federal-State Health Reform Partnership (F-SHRP). Offerors may bid on one or both tasks. The Department reserves the right to select one Offeror for both tasks or a different Offeror for each task.

Offerors should have the ability to allocate resources as required by the DOH to support the activities described in this RFP and in their bid submissions.

B. BACKGROUND

1. The Partnership Plan/Family Planning Expansion

NYS has operated a Medicaid managed care program under State law for more than a decade. In March 1995, the Department submitted an application under Section 1115 of the Social Security Act requesting approval of a demonstration project to implement a statewide mandatory Medicaid managed care program called the Partnership Plan. On July 15, 1997, the Health Care Financing Administration (HCFA) approved the Partnership Plan. The federal Centers for Medicare and Medicaid Services (CMS, formerly HCFA) has since extended the waiver several times, most recently through September 30, 2009.

The goals of the Partnership Plan include:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered; and
- Expanding coverage to additional low income New Yorkers with resources generated through managed care efficiencies.

The Partnership Plan covers most of the non-elderly, non-institutionalized Medicaid population in the State. The Terms and Conditions of the Partnership Plan define specific groups who are not eligible to join managed care. These “excluded” groups include, but are not limited to, residents of residential health care facilities, individuals who become eligible for Medicaid only after spending down a portion of their income, individuals who are residents of state-operated psychiatric facilities, individuals enrolled in managed long-term care demonstrations authorized under the State’s Public Health Law, and infants weighing less than 1200 grams at birth and other infants under six months of age who meet the criteria for Social Security Insurance (SSI) or the SSI related eligibility category.

The Partnership Plan also defines groups that are eligible for an exemption from mandatory managed care. This “exempt” group includes individuals who are HIV+, individuals who are Seriously and Persistently Mentally Ill (SPMI) and individuals who are Seriously Emotionally Disturbed except when their behavioral health benefits are available through the Medicaid fee-for-service program; individuals with end stage renal disease; and, individuals who are dually eligible for Medicare and Medicaid.

Implementation of the Partnership Plan has been phased-in geographically and by program component. Implementation of the Partnership Plan began in October 1997 in five upstate counties. Since that time, New York has implemented mandatory Medicaid managed care enrollment in 37 counties and in all five boroughs of New York City; voluntary programs operate in 12 additional counties.

In May 2001, CMS approved an amendment to the Partnership Plan to include a new program called Family Health Plus (FHPlus) for low income adults between the ages of 19 and 64 who do not have health insurance, but have incomes too high to qualify for Medicaid. FHPlus is available to single adults, couples without children and parents. Enrollment in Family Health Plus began in October 2001.

In 2002, the 1115 Demonstration was amended to include the Family Planning Expansion Program. The Family Planning Expansion program provides family planning services for two target populations: 1) Women who had been eligible for Medicaid pursuant to Section 366(4)(m)(1) of the NYS Social Services Law and who lose Medicaid eligibility at the conclusion of their 60-day postpartum period; and, 2) Women and men of childbearing age with net incomes at or below 200% of the Federal Poverty Level who are not otherwise eligible for Medicaid or other public or private health insurance coverage that provides family planning services. Medicaid services for these populations are limited to those services the primary purpose of which is family planning and which are provided in a family planning setting.

In December 2004, the Partnership Plan was further amended to permit individuals eligible for Medicare and Medicaid to enroll in Medicaid Advantage, a program designed to integrate the financing and delivery of Medicare and Medicaid benefits for dual eligibles. The first enrollments in Medicaid Advantage were in April 2005.

In November 2005, mandatory enrollment of the SSI population began in New York City and was expanded to include those with serious mental illness, effective March 1, 2007. Mandatory enrollment of SSI beneficiaries is expected to begin in five upstate counties later in 2007.

In September 2006, the CMS approved a three-year extension to the Partnership Plan waiver effective October 1, 2006 through September 30, 2009. While most of the terms and conditions of the waiver remained the same, certain populations including SSI recipients and new enrollees in the 14 counties specifically identified in the waiver's terms and conditions were moved to the F-SHRP waiver described below.

2. Federal-State Health Reform Partnership (F-SHRP)

On September 29, 2006, CMS approved New York State's request to join in a partnership to reform and restructure the State's health care delivery system. To accomplish the reform and restructuring, CMS has approved a new five-year 1115 demonstration entitled Federal-State Health Reform Partnership (F-SHRP). The waiver is effective October 1, 2006 through September 30, 2011.

The goals of this reform partnership are to promote the efficient operation of the State's health care system; consolidate and right-size New York's health care system by reducing excess capacity in the acute care system; shift emphasis in long-term care from institutional-based to community-based settings; expand the adoption of advanced health information technology and improve ambulatory and primary care provision.

Under F-SHRP, the federal government will invest up to \$1.5 billion (\$300 million per year) in agreed upon reform initiatives. The primary focus of these initiatives will be to right size and restructure the acute and long-term care delivery systems, expand the use of e-prescribing, foster the implementation of electronic medical records and regional health information organizations and expand ambulatory and primary care services.

The federal investment in these reforms is conditioned upon the following:

- The F-SHRP waiver must generate federal savings sufficient to offset the federal investment
- The State must meet a series of established performance milestones set forth in the waiver terms and conditions

The reform initiatives to right-size and restructure the State's health care delivery system and to expand use of health information technology are expected to generate significant savings to both the State and federal government. However, these reforms will be implemented over a number of years and although some of the savings are expected to accrue in the next five years, much of the savings will be long term. In order to generate sufficient federal Medicaid savings to offset its investment, CMS has agreed to count

savings in two areas – savings generated due to decreased hospital utilization resulting from eliminating excess acute care capacity and savings generated through Medicaid managed care expansions. These managed care expansions include implementation of mandatory SSI enrollment and expansion of mandatory Medicaid enrollment in 14 additional counties throughout the State. Counting these managed care savings for F-SHRP required moving these populations from the existing 1115 Partnership Plan to the new F-SHRP waiver.

In addition to demonstrating savings, F-SHRP also requires the State to meet performance milestones in the following areas:

- Increased fraud and abuse recoveries;
- Implementation of a Preferred Drug List (PDL);
- Submission of baseline data and reporting related to hospitals and nursing homes and enrollment in managed care;
- Implementation of an Employer Sponsored Insurance Initiative to increase rates of private insurance for persons covered under FHPlus;
- Implementation of Medicaid Cost Containment Initiatives;
- Improvement in ADA compliance;
- Implementation of a Single Point-of-Entry system for recipients needing long term care services;
- Reports on the progress of recommendations made by the Commission on Health Care Facilities in the 21st Century (Commission).

With the exception of the targets for fraud and abuse recoveries, failure to meet any milestone results in termination of the demonstration. A more detailed description of each Milestone can be found in Section VI paragraphs 30 through 37 of the F-SHRP Waiver (Attachment XIV).

3. New York's Medicaid Managed Care Population

New York's Medicaid managed care population includes enrollees of several programs – Medicaid Managed Care, Family Health Plus and Medicaid Advantage for dually eligible recipients.

Enrollment has grown dramatically since the start of the waiver in 1997. As of August 2007, over 2.5 million recipients were enrolled in managed care programs under the Partnership Plan. Over 2 million, representing 71% of the eligible population, are enrolled in one of 27 full-risk managed care plans that participate in the Medicaid Managed Care Program. Almost 514,000 individuals are enrolled in the FHPlus program, and 3,785 individuals are enrolled in Medicaid Advantage.

	Medicaid Managed Care	Family Health Plus	Medicaid Advantage	Total Enrolled
Upstate	547,155	132,440	372	679,967
New York City	1,498,519	381,504	3,413	1,883,436
Total	2,045,674	513,944	3,785	2,563,403

C. DETAILED SPECIFICATIONS

1. Minimum Requirements of Offerors

A qualified Offeror must have experience in the following areas, or demonstrate the capacity to establish a contractual relationship(s) with a subcontractor(s) having such experience.

a. Task 1: Evaluation of the Partnership Plan and Family Planning Expansion

Offerors must demonstrate experience in evaluation of large scale, public managed health care programs including:

- Analysis of causal relationships between activities and outcomes;
- Evaluation of quality measurement and improvement programs;
- Analysis of qualitative contextual information;
- Benchmarking.

b. Task 2: Evaluation of the F-SHRP

Offerors must demonstrate experience in quantitative and qualitative evaluation of large scale health care systems, including evaluations of hospital and nursing home restructuring and the development and implementation of health information technology systems including:

- Analysis of causal relationships between activities and outcomes;
- Longitudinal data collection and monitoring;
- Analysis of qualitative contextual information;
- Benchmarking;
- Development of recommendations to achieve stated goals.

The Offeror should complete the Transmittal Letter described in Section D.

2. Proposed Tasks

This RFP seeks to procure the services of a contractor to conduct the evaluations required by CMS as a condition of the State's 1115 Waivers. Offerors may submit a proposal for: Task 1, only; Task 2, only; or, both Task 1 and Task 2.

a. Task 1: Evaluation of the Partnership Plan and Family Planning Expansion Program

The Special Terms and Conditions of the Partnership Plan waiver extension require an evaluation of the degree to which the key goals of the Partnership Plan have been achieved and/or the key activities of the Partnership Plan have been implemented. The evaluation must, to the extent possible, isolate the contribution of the Partnership Plan to any observed effects, while also describing the relative contributions of other factors influencing the observed effects. The evaluation must also include an analysis of the impact of the family planning expansion program, particularly among the target family planning population. The successful Offeror will conduct the Partnership Plan evaluation in accordance with the Evaluation Design, included in this RFP as Attachment XIII, and consistent with the following timetable:

- February 27, 2009: Draft Demonstration/Family Planning Expansion Interim Evaluation due to the Department from the contractor for review;
- March 30, 2009: Demonstration/Family Planning Expansion Interim Evaluation due to the Centers for Medicare and Medicaid Services (CMS);
- December 28, 2009: Draft Demonstration/Family Planning Expansion Evaluation due to the Department from the contractor for review;
- January 28, 2010: Draft Demonstration/Family Planning Expansion Evaluation due to CMS;
- March 29, 2010: Comments on the draft Demonstration/Family Planning Expansion Evaluation due from CMS;
- April 28, 2010: Revised Demonstration/Family Planning Expansion Evaluation incorporating CMS comments due to the Department from the contractor for review;
- May 28, 2010: Final Demonstration/Family Planning Expansion Evaluation due to CMS.

The Special Terms and Conditions for the Partnership Plan/Family Planning Expansion programs are included in this RFP as Attachment XII.

b. Task 2: Evaluation of the Federal-State Health Reform Partnership (F-SHRP)

The Special Terms and Conditions of the F-SHRP waiver require an evaluation of the degree to which the key goals of the F-SHRP program have been achieved and/or the key activities of the F-SHRP program have been implemented. The evaluation must,

to the extent possible, isolate the contribution of the F-SHRP to any observed effects, while also describing the relative contributions of other factors influencing the observed effects. The successful Offeror will conduct the F-SHRP evaluation in accordance with the Evaluation Design, included in this RFP as Attachment XV, and consistent with the following timetable:

- April 29, 2011: Draft F-SHRP Evaluation due to the Department from the contractor for review;
- May 31, 2011: Draft F-SHRP Evaluation due to CMS;
- July 29, 2011: Comments on the draft F-SHRP Evaluation due from CMS;
- August 31, 2011: Revised F-SHRP Evaluation due to the Department from the contractor for review;
- September 30, 2011: Final F-SHRP Evaluation due to CMS.

The Special Terms and Conditions for the F-SHRP are included in this RFP as Attachment XIV.

c. Future Tasks Requiring Contract Amendment

The Department reserves the right to negotiate with the selected contractor an amendment to the contract resulting from this RFP to include additional deliverables and funding to support activities, if any, associated with extension of the Partnership Plan and/or any other Section 1115 waiver program beyond those extensions described in Tasks 1 and 2, above.

3. Letter of Interest

Offerors interested in responding to this RFP may submit the non-binding Letter of Interest, Attachment I, by the date set forth in the Schedule of Key Events, page ii of this RFP, indicating whether or not they intend to bid. The letter should specify a contact person and provide his or her mailing address, e-mail address, telephone and FAX numbers. The Letter of Interest should specify which of the following Tasks the Offeror intends to bid on:

- a) Task 1: Evaluation of the Partnership Plan and Family Planning Expansion; OR
- b) Task 2: Evaluation of the F-SHRP; OR
- c) Both Tasks 1 and 2.

Submission of the Letter of Interest is NOT mandatory, but it will ensure automatic receipt of any subsequent communications/addenda to the RFP.

Letters of Interest may be mailed, faxed or hand delivered to the attention of **Vida Wehren** at the address indicated on the Schedule of Key Events, page ii of this RFP.

4. **Bidders Conference**

A Bidders Conference will be held on the date and at the location specified in the Schedule of Key Events, page ii. At the conference, the Department will answer Offerors' questions regarding the RFP. Questions may either be submitted in advance, as explained below, or be raised during the Bidders Conference.

Information given in oral response to Bidders Conference questions will be for general information only. Official binding responses will be provided by DOH in writing, after the Bidders Conference, to all attendees and to those Offerors who submitted a Letter of Interest and will also be posted on the DOH web site at <http://www.nyhealth.gov/funding/>.

To register for the Bidders Conference, please contact the following individual by the date indicated in the Schedule of Key Events, page ii:

Vida Wehren
(518) 473-0122

5. **Questions Concerning the RFP**

The DOH encourages prospective Offerors to submit questions relating to the RFP in writing prior to the Bidders Conference. Each question must cite the particular Task (as described in item 2 above) and/or RFP section to which it refers. Questions must be received by the Department on or before 5:00 pm, Albany, New York time, at the mailing address and on the date specified as the deadline to submit written questions for Bidders Conference in the Schedule of Key Events, page ii.

From the date of issue of this RFP until the selection of a contractor, all contacts concerning the contents of this RFP must be made through **Vida Wehren** at (518) 473-0122 or by e-mail to vlw02@health.state.ny.us or FAXED to (518) 474-5886.

Offerors shall NOT communicate with any State, County or New York City representatives regarding this RFP or the RFP process during the period from release of the RFP until approval of an executed contract, with the exception of:

- Communication with designated State staff listed above;
- Communication with State staff at the Bidders Conference.

For violation of this provision, the State reserves the right to disqualify an Offeror's proposal from consideration relating to this procurement process.

Offerors must provide written affirmation that they understand and agree to comply with the procedures of the Department relative to permissible contacts, as required by §§ 139-j(3) and 139-j(6)(b) of the State Finance Law, by completing the Bid Form (see Section D.1.c.3)) of this RFP and Attachment IV.

6. Conflict of Interest

Offerors (or any subcontractor) must disclose all business relationships with or ownership interest in entities including, but not limited to health plans, providers of medical services, or organizations or trade associations representing such health plans or providers in New York State. In cases where such relationship(s) exist, Offerors must describe how the potential conflict of interest and/or disclosure of confidential information relating to this contract will be avoided.

The Department reserves the right to reject bids, at its sole discretion, based on any perceived Conflict of Interest.

7. Contract Process

Upon selection, the successful Offeror(s) will be invited to enter into an agreement(s) with the Department. The appendices contained in Attachment XVI (including the Standard Clauses for NYS Contracts, Appendix A) will form the basis of the agreement. Additionally, the contents of the selected Offeror's proposal(s), together with the RFP (and all appendices) and as amended or clarified by questions and answers, will be made part of the final agreement. The provisions of Attachment XVI, particularly Appendix A (Standard Clauses for NYS Contracts) will control.

8. Requests for Supplemental Information Regarding Proposals

During the evaluation period, Offerors may be requested to present supplemental information clarifying their proposal(s). This information must be in writing and will be included as a formal part of the Offeror's proposal(s).

9. Oral Presentations

The Department, at its own discretion, may elect to have some or all Offerors provide oral presentation of their proposal(s). Such presentations will be in the Albany area. The Offerors will be responsible for all costs associated with such presentations, including travel. In such a case, the purpose of the oral presentation will be to clarify the Offeror's proposal(s). The oral presentation will not be permitted as a means to change the content of an Offeror's proposal(s). The Key Staff assigned to this project must be present at the oral presentation.

10. Addendum to RFP

The Department reserves the right to amend the RFP. If it becomes necessary to revise any part of the RFP, addenda will automatically be provided to all prospective Offerors who submitted a Letter of Interest. Addenda will also be posted on the Department website at: www.nyhealth.gov/funding/

11. Incurred Costs

The State of New York is not liable for any cost incurred by prospective Offerors prior to the approval of an executed contract by the Comptroller of the State of New York. Additionally, no cost will be incurred by the State for any activity by the selected Contractor prior to the contract award.

12. Disclosure of Proposal Contents

To the extent permitted by law, an Offeror's proposal(s) will not be disclosed, except for purposes of evaluation, prior to approval by the Comptroller of the resulting contract. All material submitted becomes the property of the Department and may be returned at the Department's discretion. Submitted proposals may be reviewed and evaluated by any person, other than one associated with a competing Offeror, designated by the Department. If an Offeror believes that any information in its proposal(s) constitutes a trade secret and wishes such information not to be disclosed if requested by a member of the public pursuant to the State Freedom Of Information Law, Article 6, of the Public Officers Law, the Offeror shall submit with its proposal(s) a letter specifically identifying by page number, line or other appropriate designation that information which is a trade secret and explaining in detail why such information is a trade secret. Failure by an Offeror to submit such a letter with its offer identifying trade secrets shall constitute a waiver by the Offeror of any rights it may have under Section 89, Subdivision 5, of the Public Officers Law relating to protection of trade secrets.

13. Documents Available on the DOH Website

The NYS DOH website (www.nyhealth.gov/funding/) offers a number of documents that may be of interest to potential Offerors. These documents include the Partnership Plan waiver extension request, the Terms and Conditions for the Partnership Plan and F-SHRP waivers, Medicaid Managed Care Enrollment Reports, the NYS Operational Protocol for the Partnership Plan Program and Managed Care Model Contracts for the Medicaid Managed Care, Family Health Plus and Medicaid Advantage Programs.

D. PROPOSAL REQUIREMENTS

1. Information Required From Offerors

a. Format for Required Information

Offerors may submit proposals for EITHER Task 1 OR Task 2 OR BOTH Task 1 and Task 2. Offerors submitting proposals for both Task 1 and Task 2 MUST submit separate Technical and Cost Proposals for each Task. Proposals shall be prepared in the format described in Sections b. Technical Proposal and c. Cost Proposal, below. The format of the proposals must follow, in sequence, each of the sections outlined below. Appendices should be similarly sequential. Proposals must

be signed by an official authorized to bind the Offeror to its provisions. Proposals which do not address all requirements of this RFP may be considered non-responsive, resulting in rejection of the proposal.

b. Technical Proposal

The Technical Proposal will contribute 70% toward the Offeror's overall score for each Proposal submitted. No financial information is to be included in the Technical Proposal.

The Technical Proposal(s) must be submitted separately from the Cost Proposal(s), as described in Section E.3. Offerors submitting proposals for both Task 1 and Task 2 must submit two complete and separate Technical Proposals.

Each Technical Proposal must consist of the following information. **Proposals that do not include all the requirements listed in sections 1) through 5), below, may be considered non-responsive, resulting in rejection of the Proposal(s).**

1) Transmittal Letter

The Transmittal Letter must be signed in ink by an official authorized to bind the organization to the provisions of the RFP and Proposal.

The Transmittal Letter must include:

- a) Identification of the person who will serve as primary contact for the State's Issuing Officer and that person's address, telephone and fax numbers.
- b) Disclosure of any relationships and/or ownership interest that may represent a conflict of interest for the Offeror and/or any subcontractor or a statement that no such relationship exists. In cases where such a relationship does exist, describe how the potential conflict of interest and/or disclosure of confidential information relating to this contract will be avoided.
- c) The name, title and responsibilities of all officers, identifying those who are authorized to negotiate a contract with the Department and who will have ultimate responsibility and accountability for this contract.
- d) A description of any relevant litigation, charges, convictions, or disciplinary actions in which the Offeror is presently involved that may affect the Offeror's ability to perform with regard to this project or a statement that no such actions exist.

2) Required Forms

In addition to the Transmittal Letter, the Offeror must complete the following Required Forms, which can be found in the Attachments referenced below:

- Attachment II – Offeror’s Assurances
- Attachment III – Offeror’s Questionnaire
- Attachment VI – Vendor Responsibility Questionnaire
- Attachment XI – NYS Taxation and Finance Form ST-220-CA
- Attachment XVII – Vendor Responsibility Attestation

3) Subcontractors

For each proposed subcontractor:

- a) Provide the full name and address of any organization with which the Offeror will subcontract for any services under the project. Describe the services the subcontractor will provide and how such services will be coordinated and managed by the Offeror. Describe the existing business relationship between the Offeror and the proposed subcontractor(s), including a brief description of the projects on which the Offeror and subcontractor are currently working.
- b) List responsible officers of each subcontractor, including those individuals authorized to negotiate for subcontractors.
- c) List any financial interest the Offeror has in proposed subcontractors, or provide a statement that no such interest exists.
- d) Provide evidence of all potential subcontractors’ willingness to participate or enter into sub-contractual arrangements.
- e) Provide a description of any relevant litigation (pending or final), judgments, convictions and pending or final disciplinary actions for the subcontractor that may affect the ability to perform with regard to this project, or provide a statement that no such actions exist.
- f) Provide a Vendor Responsibility Questionnaire and a Vendor Responsibility Attestation for any subcontractor that is known at the time of proposal submission and whose subcontract will equal or exceed \$100,000 in any year during the contract period (see Attachment VI).

4) New York State Contract Work

List any New York State contract work within the previous five years for the Offeror and any of its proposed subcontractors. Include the following:

- a) State contracting agency
- b) Contact person
- c) Telephone number of contact person
- d) Project dollar amount
- e) Time frame
- f) Brief statement of the work performed.

5) Response to Offeror's Questionnaire

Provide a response to all sections of the Offeror's Questionnaire included in Attachment III to this RFP.

c. Cost Proposal

This is a competitive procurement, which will result in one or two fixed price contracts.

Offerors submitting proposals for both Task 1 and Task 2 must submit two complete and separate Cost Proposals. The Cost Proposal will contribute 30% toward the Offeror's overall score for each Proposal submitted.

The Cost Proposal must consist of the following information. **Proposals that do not include all the requirements listed in sections 1) through 3), below, may be considered non-responsive, resulting in rejection of the Proposal(s).**

1) Cost Transmittal Letter

The Cost Transmittal Letter must be signed in ink by an individual authorized to bind the Offeror to its provisions. It must include a statement of assurance that the offer will remain valid and not subject to change for a minimum of 270 days from the Proposal Due Date shown in the Schedule of Key Events on page ii of this RFP.

2) Cost Proposal Form

This RFP will result in a fixed price contract. Offerors must complete one Cost Proposal Form, Attachment VII, for each Task the Offeror bids on. Offerors should complete the Cost Proposal Form based on the following:

- a) The hourly rates must be inclusive of all costs including salaries, fringe benefits, administrative costs, overhead, travel, presentation costs and

- profit.
- b) Include the title and composite hourly rate for each staff person that will work on the project.
- c) The total bid price must reflect all costs for the full term of the contract.

3) Required Forms

- Attachment IV – Bid Form
- Attachment VIII – State Consultant Services Form A, Contractor’s Planned Employment from Contract Start Date through End of Contract Term

2. Method of Award

a. Vendor Selection

Proposals from Offerors submitting proposals for both Task 1 and Task 2 will be evaluated and scored separately. The Department reserves the right to select one Offeror for both Tasks 1 and 2 or to select a different Offeror for each Task. At the discretion of the Department of Health, all bids may be rejected. The evaluation of the bids will include, but not be limited to the following considerations:

1. Task 1: Evaluation of the Partnership Plan and Family Planning Expansion

a) Evaluation and Selection Committees

The Technical and Cost Proposals will be evaluated separately by a Technical Evaluation Committee and a Financial Evaluation Committee, respectively. These committees will report to a Selection Committee who will select the proposal which best meets the requirements of the Department.

b) Evaluation Criteria

All proposals received shall be subject to an evaluation, for the purposes of selecting the Offeror with whom a contract will be signed. The review will include, but not be limited to, the proposal’s compliance with the terms, conditions, and other provisions contained in this RFP; the responsiveness of the Offeror’s Technical Proposal to the requirements of the Department as specified in the RFP; qualifications and experience of the Offeror’s assigned personnel and prior experience of the Offeror; and total cost of the proposal.

The scoring will be performed as follows:

1) Minimum Requirements

Initially, all proposals will be screened to determine adherence to RFP requirements. Proposals found to be non-responsive may be eliminated from further consideration.

Proposals will be evaluated for technical content.

2) Technical Score

Proposals will be evaluated and scored by the Technical Evaluation Committee using a weighted point system. The evaluation of the Offeror's Technical Proposal will be based on the written Proposal; information obtained through reference checks; and as deemed necessary, site visits or an oral presentation conducted to clarify the Offeror's proposed technical approach.

The raw technical scores will be converted to a scale where the highest scoring proposal receives 100 points and the remaining proposals receive proportional scores based on their relationship to the top score.

3) Cost Score

The Department will compute the Cost Score for each Offeror based on information included in Attachment VII, again using a weighted point system.

4) Total Combined Score

The Technical Score and the Cost Score will be combined into a Total Combined Score, using the following formula:

$$\frac{\begin{array}{r} \text{Technical Score times} \quad (70\%) \\ + \text{Cost Score times} \quad (30\%) \end{array}}{\text{Total Combined Score}}$$

5) Selection

The Department will select the highest ranking proposal submitted by an Offeror that is determined responsible.

2. Task 2: Evaluation of the Federal-State Health Reform Partnership (F-SHRP)

a) Evaluation and Selection Committees

The Technical and Cost Proposals will be evaluated separately by a Technical Evaluation Committee and a Financial Evaluation Committee, respectively. These committees will report to a Selection Committee who will select the proposal which best meets the requirements of the Department.

b) Evaluation Criteria

All proposals received shall be subject to an evaluation, for the purposes of selecting the Offeror with whom a contract will be signed. The review will include, but not be limited to, the proposal's compliance with the terms, conditions, and other provisions contained in this RFP; the responsiveness of the Offeror's Technical Proposal to the requirements of the Department as specified in the RFP; qualifications and experience of the Offeror's assigned personnel and prior experience of the Offeror; and total cost of the proposal.

The scoring will be performed as follows:

1) Minimum Requirements

Initially, all proposals will be screened to determine adherence to RFP requirements. Proposals found to be non-responsive may be eliminated from further consideration.

Proposals will be evaluated for technical content.

2) Technical Score

Proposals will be evaluated and scored by the Technical Evaluation Committee using a weighted point system. The evaluation of the Offeror's Technical Proposal will be based on the written Proposal; information obtained through reference checks; and as deemed necessary, site visits or an oral presentation conducted to clarify the Offeror's proposed technical approach.

The raw technical scores will be converted to a scale where the highest scoring proposal receives 100 points and the remaining proposals receive proportional scores based on their relationship to the top score.

3) Cost Score

The Department will compute the Cost Score for each Offeror based on information included in Attachment VII, again using a weighted point system.

4) Total Combined Score

The Technical Score and the Cost Score will be combined into a Total Combined Score, using the following formula:

$$\frac{\begin{array}{r} \text{Technical Score times} \quad (70\%) \\ + \text{Cost Score times} \quad (30\%) \end{array}}{\text{Total Combined Score}}$$

5) Selection

The Department will select the highest ranking proposal submitted by an Offeror that is determined responsible.

b. Notification of Award

After evaluation and selection of the proposal(s), all Offerors will be notified in writing of the acceptance or rejection of their proposals. The name of the successful Offeror(s) may be disclosed. Press releases pertaining to this project shall not be made without prior written approval by the Department and then only in conjunction with the Issuing Agency identified in this RFP.

c. Contract Process

Upon selection, the successful Offeror(s) will be invited to enter into an agreement(s) with the Department. All appendices contained in Attachment XVI (including the Standard Clauses for NYS Contracts, Appendix A), will form the basis of the agreement(s). Additionally, the contents of the selected Offeror's or Offerors' proposals, together with the RFP (including all Appendices), and any questions and answers passed during the procurement process, will be made part of the final agreement. The provisions of Attachment XVI, particularly Appendix A (Standard Clauses for NYS Contracts) will control.

d. Acceptance of Deliverables and Payments

Payments will be made for satisfactory performance of the services described, based on the contractual fixed price, as agreed upon by the Contractor(s) and the Department, up to the maximum amount payable under the contract(s).

All claims for payment will be submitted on a New York State Standard Voucher with backup information in a form satisfactory to the Department and the Comptroller of the State of New York.

E. ADMINISTRATIVE

1. Issuing Agency

This RFP is a solicitation issued by the NYS Department of Health. The Department is responsible for the requirements specified herein and for the evaluation of all proposals.

2. Inquiries

Any questions concerning this solicitation should be directed to:

Vida Wehren
NYS Department of Health
Office of Health Insurance Programs
Empire State Plaza
Corning Tower Building, Room 1927
Albany, NY 12237

Questions and answers, as well as any RFP updates and/or modifications, will be posted on the Department of Health's website at <http://www.nyhealth.gov/funding/> by the date indicated in the Schedule of Key Events, page ii. Bidders that submit a Letter of Interest will automatically receive these documents via mail.

See Section C.4 for details on the Bidders Conference.

3. Submission of Proposals

a. Submission Summary

Interested Offerors should submit an original and five signed copies plus one unbound copy of each of their Bid Proposal(s) not later than 5:00 P.M., Albany, New York time on the Proposal Due date listed on the Schedule of Key Events on page ii of this RFP. For further details regarding the submission, see Section E.3.b., Requirements for Submission of Proposal(s), below.

Responses to the proposal should be clearly marked as described in Section E.3.b., Requirements for Submission of Proposal(s), below and directed to:

New York State Department of Health
Office of Health Insurance Programs
Empire State Plaza
Corning Tower, Room 1927
Albany, NY 12237
Attention: Vida Wehren

It is the Offerors' responsibility to see that bids are delivered to the Empire State Plaza, Corning Tower, Room 1927 prior to the date and time of the bid due date. Late bids due to delay by the carrier or not received in the Department's mail room in time for transmission to Room 1927 will not be considered.

- ❑ The Bid Form must be filled out in its entirety.
- ❑ The responsible corporate officer for contract negotiation must be listed and this document must be signed by the responsible corporate officer.
- ❑ All evidence and documentation requested under Section D, Proposal Requirements, must be provided at the time the proposal is submitted.

b. Requirements for Submission of Proposal(s)

The following are general requirements to which an Offeror must adhere in submitting a proposal(s) in response to the RFP:

- 1) Offerors wishing to submit proposals for both Task 1 and Task 2 must submit two separate and complete proposals – one for each Task.
- 2) Offerors must clearly label each component of the proposal as either “Task 1: Partnership Plan Evaluation”; or, “Task 2: F-SHRP Evaluation”. Further, the Offeror must submit its proposal(s) in two parts: Technical and Cost. Information required from Offerors and a detailed explanation of the required format for the Technical and Cost proposals are contained in Section D, Proposal Requirements;
- 3) To facilitate the evaluation process, the Offeror is required to submit one original, 5 bound copies, and one unbound copy of both the Cost and Technical Proposal(s) (7 complete signed sets in all for each proposal);
- 4) The Technical and Cost portions of the proposal(s) must be separately bound and placed in separately sealed envelopes labeled as either Task 1 or Task 2 AND either Cost or Technical. No cost information should be contained in the Technical Proposal. Both parts, however, should be submitted in the same package. The package(s) must indicate the following on the outside:
 - ✓ Offeror's Name and Address
 - ✓ NYS DOH Response to Program Evaluation of Section 1115 Waiver Programs RFP
 - ✓ Proposal Due Date
- 5) All copies of the proposal(s) must be properly identified and mailed or hand delivered to the person and address listed in Section E.3.a., above.

- 6) Proposals must be received by the Department on or before 5:00 P.M., Albany, New York time on the Proposal Due Date and mailing address set forth in the Schedule of Key Events on page ii of the RFP. Any Offeror's proposal made in response to this RFP not received by 5:00 P.M. on the closing date for receipt of proposals will not be accepted.
- 7) The Offeror must allow sufficient time for mail delivery to ensure receipt of its proposal(s) by the specified time and should utilize certified or registered mail with return receipt requested. NO FAX COPIES WILL BE ACCEPTED.

4. Department of Health Rights

The Department of Health reserves the right to:

- a. Reject any or all proposals received in response to this RFP.
- b. Waive or modify minor irregularities in proposals received after prior notification to the Offeror.
- c. Adjust or correct cost or cost figures with the concurrence of Offeror if errors exist and can be documented to the satisfaction of DOH and the State Comptroller.
- d. Negotiate with Offerors responding to this RFP within the requirements to serve the best interests of the State.
- e. Eliminate mandatory requirements unmet by all Offerors.
- f. If the Department of Health is unsuccessful in negotiating a contract with the selected vendor within an acceptable time frame, the Department of Health may begin contract negotiations with the next qualified vendor(s) in order to serve and realize the best interests of the State.

5. Payment

If awarded a contract, the contractor shall submit invoices to the State's designated payment office:

New York State Department of Health
Office of Health Insurance Programs
Empire State Plaza
Corning Tower, Room 1927
Albany, New York 12237
Attention: Vida Wehren

Payment of such invoices 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:

- a. In consideration of the Contractor's satisfactory performance of the services described in the Agreement, the Department agrees to pay the Contractor the contracted fixed price.
- b. The State will issue payments to the Contractor at the percentages shown in the following schedules, provided that the Contractor has provided the corresponding deliverables to the State's satisfaction.

Task 1 Schedule: Partnership Plan/Family Planning Expansion

Deliverable	Percentage Payment	Description of Deliverable
First Status Report	15%	Contractor will submit periodic Status Reports, according to a schedule to be determined by the Department. The first Status Report will be due 3 months after approval of the Contract by the Office of the State Comptroller. Upon receipt of the First Status Report, the Contractor will receive a payment of 15% of the Contract value.
Draft Interim Evaluation Submitted to DOH for Comment	20%	Draft Interim Evaluation submitted to the Department for review in accordance with the timetable in Section C.2. Content and organization of the Interim Evaluation must be satisfactory to the Department.
Draft Interim Evaluation Incorporating DOH Changes Submitted to DOH	10%	Draft Interim Evaluation, incorporating the Department's comments, submitted consistent with the timetable in Section C.2. Content and organization of the Interim Evaluation must be satisfactory to the Department.
Draft Evaluation Submitted to DOH for Comment	20%	Draft Evaluation submitted to the Department for review in accordance with the timetable in Section C.2. Content and organization of the Evaluation must be satisfactory to the Department.
Draft Evaluation Incorporating DOH Changes Submitted to DOH	10%	Draft Evaluation, incorporating the Department's comments, submitted consistent with the timetable in Section C.2. Content and organization of the Evaluation must be satisfactory to the Department.
Final Evaluation Incorporating CMS Changes Submitted to DOH for Comment	15%	Final Evaluation submitted to the Department for review in accordance with the timetable in Section C.2. Content and organization of the Evaluation must be satisfactory to the Department.
Final Evaluation Incorporating DOH Changes Submitted to DOH	10%	Final Evaluation, incorporating the Department's comments, submitted consistent with the timetable in Section C.2. Content and organization of the Evaluation must be satisfactory to the Department.
Consultation after Submission of Final Evaluation Report	0%	The Contractor will continue to be available to the Department to respond to any questions or concerns that arise after submission of the Final Evaluation Report to CMS until the contract end date.

Task 2 Schedule: F-SHRP

Deliverable	Percentage Payment	Description of Deliverable
First Status Report	20%	Contractor will submit periodic Status Reports, according to a schedule to be determined by the Department. The first Status Report will be due 3 months after approval of the Contract by the Office of the State Comptroller. Upon receipt of the First Status Report, the Contractor will receive a payment of 20% of the Contract value.
Draft Evaluation Submitted to DOH for Comment	40%	Draft Evaluation submitted to the Department for review in accordance with the timetable in Section C.2. Content and organization of the Evaluation must be satisfactory to the Department.
Draft Evaluation Incorporating DOH Changes Submitted to DOH	10%	Draft Evaluation, incorporating the Department’s comments, submitted consistent with the timetable in Section C.2. Content and organization of the Evaluation must be satisfactory to the Department.
Final Evaluation Incorporating CMS Changes Submitted to DOH for Comment	15%	Final Evaluation submitted to the Department for review in accordance with the timetable in Section C.2. Content and organization of the Evaluation must be satisfactory to the Department.
Final Evaluation Incorporating DOH Changes Submitted to DOH	15%	Final Evaluation, incorporating the Department’s comments, submitted consistent with the timetable in Section C.2. Content and organization of the Evaluation must be satisfactory to the Department.
Consultation after Submission of Final Evaluation Report	0%	The Contractor will continue to be available to the Department to respond to any questions or concerns that arise after submission of the Final Evaluation Report to CMS until the contract end date.

- c. The Contractor represents and agrees to submit all claims for payment in a form satisfactory to the Department and the Comptroller of the State of New York.
- d. The Department shall not be liable for the payment of any taxes under the Agreement, however designated, levied or imposed.

6. Term of Contract

The agreement will be for a five-year period.

This Agreement shall be effective upon approval of the NYS Office of the State Comptroller. The beginning date of the contract period will be the date the contract is signed by the Office of the State Comptroller. The anticipated contract period is July 21, 2008 – July 20, 2013.

This Agreement may be canceled at any time by the Department of Health giving to the Contractor not less than thirty (30) days written notice that on or after a date therein specified this Agreement shall be deemed terminated and cancelled.

7. Debriefing

Once an award has been made, Offerors may request a debriefing of their proposal. Please note the debriefing will be limited only to the strengths and weaknesses of the Offeror's proposal, and will not include any discussion of other proposals. Requests must be received no later than three months from date of award announcement.

8. Vendor Responsibility Questionnaire

New York State Procurement Law requires that state agencies award contracts only to responsible vendors. Vendors are invited to file the required Vendor Responsibility Questionnaire online via the New York State VendRep System or may choose to complete and submit a paper questionnaire. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at www.osc.state.ny.us/vendrep or go directly to the VendRep system online at <https://portal.osc.state.ny.us>. For direct VendRep System user assistance, the OSC Help Desk may be reached at 866-370-4672 or 518-408-4672 or by email at helpdesk@osc.state.ny.us. Vendors opting to file a paper questionnaire can obtain the appropriate questionnaire from the VendRep website www.osc.state.ny.us/vendrep or may contact the Department of Health or the Office of the State Comptroller for a copy of the paper form. Bidders must also complete and submit the Vendor Responsibility Attestation (Attachment XVII).

In addition to the Questionnaire and Attestation, bidders are required to provide the following with their proposal:

- Proof of financial stability in the form of audited financial statements, Dunn & Bradstreet Reports, etc.
- Department of State Registration.
- Certificate of Incorporation, together with any and all amendments thereto; Partnership Agreement; or other relevant business organizational documents, as applicable.
- N.Y.S. Dept of Taxation and Finance's Contractor Certification Form ST-220-CA.

9. State Consultant Services Reporting

Chapter 10 of the Laws of 2006 amended certain sections of State Finance Law and Civil Service Law to require disclosure of information regarding contracts for consulting services in New York State.

The winning bidders 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.

Winning bidders 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.

Both of these forms are included as attachments to this document.

10. Lobbying Statute

Chapter 1 of the Laws of 2005, as amended by Chapter 596 of the Laws of 2005, provides, among other things, the following as pertains to development of procurement contracts with governmental entities:

- a. makes 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. requires the above mentioned 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. requires 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. authorizes the Temporary State Commission on Lobbying 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. directs 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. requires the timely disclosure of accurate and complete information from offerers with respect to determinations of non-responsibility and debarment;
- g. expands the definition of lobbying to include attempts to influence gubernatorial or local Executive Orders, Tribal-State Agreements, and procurement contracts;

- h. modifies the governance of the Temporary State Commission on lobbying;
- i. provides that opinions of the Commission shall be binding only on the person to whom such opinion is rendered;
- j. increases the monetary threshold which triggers a lobbyist's obligations under the Lobbying Act from \$2,000 to \$5,000; and
- k. establishes the Advisory Council on Procurement Lobbying.

Generally speaking, two related aspects of procurements were amended: (i) activities by the business and lobbying community seeking procurement contracts (through amendments to the Legislative Law) and (ii) activities involving governmental agencies establishing procurement contracts (through amendments to the State Finance Law).

Additionally, a new section 1-t was added to the Legislative Law establishing an Advisory Council on Procurement Lobbying (Advisory Council). This Advisory Council is authorized to establish the following model guidelines regarding the restrictions on contacts during the procurement process for use by governmental entities (see Legislative Law §1-t (e) and State Finance Law §139-j). In an effort to facilitate compliance by governmental entities, the Advisory Council has prepared model forms and language that can be used to meet the obligations imposed by State Finance Law §139-k, Disclosure of Contacts and Responsibility of Offerers. Sections 139-j and 139-k are collectively referred to as "new State Finance Law."

It should be noted that while this Advisory Council is charged with the responsibility of providing advice to the New York Temporary State Commission on Lobbying (Lobbying Commission) regarding procurement lobbying, the Lobbying Commission retains full responsibility for the interpretation, administration and enforcement of the Lobbying Act established by Article 1-A of the Legislative Law (see Legislative Law §1-t (c) and §1-d). Accordingly, questions regarding the registration and operation of the Lobbying Act should be directed to the Lobbying Commission.

11. Accessibility of State Agency Web-based Intranet and Internet Information and Applications

Any web-based intranet and internet information and applications development, or programming delivered pursuant to the contract or procurement will comply with NYS Office for Technology Policy P04-002, "Accessibility of New York State Web-based Intranet and Internet Information and Applications", and NYS Mandatory Technology Standard S04-001, as such policy or standard may be amended, modified or superseded, which requires that state agency web-based intranet and internet information and applications are accessible to persons with disabilities. Web content must conform to NYS Mandatory Technology Standard S04-00, as determined by quality assurance testing. Such quality assurance testing will be conducted by Department of Health, contractor or other, and the results of such testing must be satisfactory to the Department of Health before web content will be considered a qualified deliverable under the contract or procurement.

12. Information Security Breach and Notification Act

Section 208 of the State Technology Law (STL) and Section 899-aa of the General Business Law (GBL) require that State entities and persons or businesses conducting business in New York who own or license computerized data which includes private information including an individual's unencrypted personal information plus one or more of the following: social security number, driver's license number or non-driver ID, account number, credit or debit card number plus security code, access code or password which permits access to an individual's financial account, must disclose to a New York resident when their private information was, or is reasonably believed to have been, acquired by a person without valid authorization. Notification of breach of that private information to all individuals affected or potentially affected must occur in the most expedient time possible without unreasonable delay, after measures are taken to determine the scope of the breach and to restore integrity; provided, however, that notification may be delayed if law enforcement determines that expedient notification would impede a criminal investigation. When notification is necessary, the State entity or person or business conducting business in New York must also notify the following New York State agencies: the Attorney General, the Office of Cyber Security & Critical Infrastructure Coordination (CSCIC) and the Consumer Protection Board (CPB). Information relative to the law and the notification process is available at: <http://www.cscic.state.ny.us/security/securitybreach/>

13. New York State Tax Law Section 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.

Contractor must complete and submit directly to the New York State Taxation and Finance, Contractor Certification Form ST-220-TD attached hereto. Unless the information upon which the ST-220-TD is based changes, this form only needs to be filed once with DTF. If

the information changes for the contractor, its affiliate(s), or its subcontractor(s), a new form (ST-220-TD) must be filed with DTF.

Contractor must complete and submit to the Department of Health the form ST-220-CA attached hereto, certifying that the contractor filed the ST-220-TD with DTF. Failure to make either of these filings may render an offerer non-responsive and non-responsible. Offerers shall take the necessary steps to provide properly certified forms within a timely manner to ensure compliance with the law.

F. APPENDICES

The following will be incorporated as appendices into any contracts resulting from this Request for Proposal. This Request for Proposal will, itself, be referenced as an appendix of the contract.

- APPENDIX A - Standard Clauses for All New York State Contracts
- APPENDIX B - Request for Proposals
- APPENDIX C - Proposal
The Offeror's proposal (if selected for award), including any Bid Forms and all proposal requirements.
- APPENDIX D - General Specifications
- APPENDIX E
Unless the CONTRACTOR is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the CONTRACTOR's insurance carrier and/or the Workers' Compensation Board, of coverage for:
 - Workers' Compensation, for which one of the following is incorporated into this contract as **Appendix E-1**:
 - **WC/DB-100**, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
 - **C-105.2** – Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the **U-26.3**; OR
 - **SI-12** – Certificate of Workers' Compensation Self-Insurance, OR **GSI-105.2** – Certificate of Participation in Workers' Compensation Group Self-Insurance.

- Disability Benefits coverage, for which one of the following is incorporated into this contract as **Appendix E-2**:
 - **WC/DB-100**, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
 - **DB-120.1** – Certificate of Disability Benefits Insurance; OR
 - **DB-155** – Certificate of Disability Benefits Self-Insurance.
- APPENDIX H – Health Insurance Portability and Accountability Act (HIPAA) (if applicable)

G. Attachments

- I Letter of Interest
- II Offeror's Assurances
- III Offeror's Questionnaire
- IV Bid Form
- V No Bid Form
- VI Vendor Responsibility Questionnaires (For-Profit and Not-For-Profit)
- VII Cost Proposal Form
- VIII State Consultant Services Form A
- IX State Consultant Services Form B
- X NYS Taxation and Finance Form ST-220-TD
- XI NYS Taxation and Finance Form ST-220-CA
- XII Special Terms and Conditions for the Partnership Plan and Family Planning Expansion
- XIII Evaluation Design for the Partnership Plan and Family Planning Expansion
- XIV Special Terms and Conditions for the Federal-State Health Reform Partnership (F-SHRP)
- XV Evaluation Design for the Federal-State Health Reform Partnership (F-SHRP)
- XVI Contract Appendices
 - Appendix A - Standard Clauses for NYS Contracts
 - Appendix D - General Specifications
 - Appendix H - Federal Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement
- XVII Vendor Responsibility Attestation
- XVIII Offeror's List of Required Items

ATTACHMENT I
New York State Department of Health
Office of Health Insurance Programs
Letter Of Interest
for
Partnership Plan/F-SHRP Program Evaluation

To: Vida Wehren
New York State Department of Health
Office of Health Insurance Programs
Empire State Plaza - Corning Tower, Room 1927
Albany, NY 12237

I recognize that I have the opportunity to compete in a bid process to contract with New York State to perform program evaluation services. I further understand that the successful Offeror(s) will engage in a contract for a five (5) year period.

It is understood that this Letter of Interest is not binding on either party but simply alerts the Department of Health of the Offeror's intentions and assures the Offeror will receive all further correspondence on this RFP, if submitted with 'Yes' checked.

Yes I am interested in competing in a bid process for the following program evaluation services (check one) for the Office of Health Insurance Programs. I understand that this letter of interest is non-binding.

Partnership Plan/Family Planning Expansion Evaluation
 F-SHRP Evaluation
 BOTH of the above Evaluations

Contact Person: _____
Organization: _____
Address: _____

E-mail Address: _____
Phone: _____
FAX Number: _____

No I am not interested in competing in a bid process for program evaluation services for the Office of Health Insurance Programs for the following reasons:

Signed: _____ Date: _____
(Person having authority to enter into a contractual agreement.)

ATTACHMENT II

Offeror's Assurances

The Offeror's Assurances form **MUST** be signed in ink by an official authorized to bind the organization to the provisions of the RFP and Proposal. **Proposals which do not include this signed form will be considered non-responsive, resulting in rejection of the Proposal.**

- a) The Offeror is willing and ready to provide the services defined in the RFP in a timely manner.
- b) The Offeror is financially able to perform the tasks related to this project.
- c) The Offeror agrees to the proposed contract language, as defined in the RFP and all appendices, except to the extent that the Offeror sets forth, within the Transmittal Letter, explicit exceptions or modifications that are clearly identified as such. The Offeror understands that any such exceptions or modifications are not binding until agreed to by the Department and approved by the Office of the State Comptroller and the Attorney General. The Offeror further understands that, depending on the nature of the exceptions or requested modifications, such exceptions or requested modifications may render the Offeror's proposal non-responsive and, hence, lead to its rejection.
- d) The Offeror assures that the proposal will remain valid and not subject to change for a minimum period of 270 days from the proposal due date.
- e) The Offeror assures that no funds were paid or will be paid, by or on behalf of the Offeror, to any person for the purpose of influencing or attempting to influence any officer or employee of the federal or State government with regard to obtaining a contract.
- f) The Offeror assures its ability to perform all services required under the contract, or, if the Offeror intends to subcontract, the Offeror assures that it will perform the majority of services under the contract and will retain all management and oversight responsibilities.
- g) The Offeror agrees to meet the criteria for the Federal Health Insurance Portability and Accountability Act (HIPAA) as found in the Business Associate Agreement found in Appendix H of Attachment XVI.
- h) The Offeror agrees to comply with the requirements of the Procurement Lobbying Statute. The Offeror has also completed, and returned with the proposal, the "Bid Form" included in Attachment IV of this RFP.
- i) The Offeror agrees to disclose information as required by the Consultant Disclosure Legislation. The Offeror has also completed, and returned with the proposal, "State Consultant Services Form A, Contractor's Planned Employment from Contract Start Date through End of Contract Term", included in this RFP as Attachment VIII.

- j) The Offeror assures that it conforms to vendor responsibility requirements of State Finance Law. The Offeror has also completed, and returned with the proposal, the “Vendor Responsibility Questionnaire” (Attachment VI) and all other related documentation listed in Section E.8. of this RFP.

Signature of Authorized Official

Date

ATTACHMENT III

Offeror's Questionnaire

Core tasks related to this RFP include:

A. Task 1: Evaluation of the Partnership Plan and Family Planning Expansion

1. Describe your company's experience, and the experience of any proposed subcontractors, in evaluation of large scale public managed health care programs, including:
 - Analysis of causal relationships between activities and outcomes;
 - Evaluation of quality measurement and improvement programs;
 - Analysis of qualitative contextual information;
 - Benchmarking.

2. Identify Key Staff essential to the work to be performed under this RFP. Include the following:
 - Organizational chart showing the reporting relationships of the staff that you propose to assign to the contract, including subcontractors, if applicable;
 - Resume for each of the Key Staff identified.

3. Provide the information shown below for three (3) current and/or former clients (other than NYS clients) for whom you provided services during the previous five years, that can provide references for similar evaluation activities. This should include references for work performed by a subcontractor for this task if applicable.
 - Name and telephone number of contact
 - Organization name and address
 - Description of services performed
 - Dates when services were performed
 - Staff assigned to this proposal who worked on the referenced project and a description of their role on the referenced project.

4. For each of the following components of the Partnership Plan Evaluation Design (see Attachment XIII), describe your proposed approach to evaluating the State's achievement of each of the following goals and include data needs, planned interviews and design methods:
 - Goal 1: Continue managed care enrollment in New York's Medicaid program
 - Goal 2: Improve health care access for Medicaid managed care enrollees
 - Goal 3: Improve quality of care for Medicaid managed care enrollees
 - Goal 4: Expand health care coverage to uninsured New Yorkers
 - Goal 5: Avert unintended pregnancies within target population

B. Task 2: Evaluation of the Federal-State Health Reform Partnership

1. Describe your company's experience, and the experience of any proposed subcontractors, in evaluation of large scale health care systems, including restructuring of hospital and nursing home delivery systems and the development and implementation of health information technology systems, including:
 - Analysis of causal relationships between activities and outcomes;
 - Longitudinal data collection and monitoring;
 - Analysis of qualitative contextual information;
 - Benchmarking;
 - Development of recommendations to achieve stated goals.

2. Identify Key Staff essential to the work to be performed under this RFP. Include the following:
 - Organizational chart showing the reporting relationships of the staff that you propose to assign to the contract, including subcontractors, if applicable;
 - Resume for each of the Key Staff identified.

3. Provide the information shown below for three (3) current and/or former clients (other than NYS clients), for whom you provided services during the previous five years, that can provide references for similar evaluation activities. This should include references for work performed by a subcontractor for this task if applicable.
 - Name and telephone number of contact
 - Organization name and address
 - Description of services performed
 - Dates when services were performed
 - Staff assigned to this proposal who worked on the referenced project and a description of their role on the referenced project.

4. For each of the following components of the F-SHRP Evaluation Design (see Attachment XV), describe your proposed approach to evaluating the State's achievement of each of the following goals:
 - Goal 1: Restructure the acute care system to promote access to high quality, cost effective care
 - Goal 2: Restructure the long term care system to create more community based long term care options
 - Goal 3: Promote the use of health information technology to improve quality of care, reduce medical errors and increase efficiency in New York's health care system
 - Goal 4: Expand Medicaid managed care to slow the growth of Medicaid expenditures and provide more efficient service delivery to Medicaid beneficiaries

ATTACHMENT IV

**NEW YORK STATE
DEPARTMENT OF HEALTH**

BID FORM

PROCUREMENT TITLE: _____ FAU # _____

Bidder Name:
Bidder Address:

Bidder Fed ID No:

A. _____ bids a total price of \$ _____
(Name of Offerer/Bidder)

B. Affirmations & Disclosures related to State Finance Law §§ 139-j & 139-k:

Offerer/Bidder affirms that it understands and agrees to comply with the procedures of the Department of Health relative to permissible contacts (provided below) as required by State Finance Law §139-j (3) and §139-j (6) (b).

Pursuant to State Finance Law §§139-j and 139-k, this *Invitation for Bid or Request for Proposal* includes and imposes certain restrictions on communications between the Department of Health (DOH) and an Offerer during the procurement process. An Offerer/bidder is restricted from making contacts from the earliest notice of intent to solicit *bids/proposals* through final award and approval of the Procurement Contract by the DOH and, if applicable, Office of the State Comptroller (“restricted period”) to other than designated staff unless it is a contact that is included among certain statutory exceptions set forth in State Finance Law §139-j(3)(a). Designated staff, as of the date hereof, is/are identified on the first page of this *Invitation for Bid, Request for Proposal, or other solicitation document*. DOH employees are also required to obtain certain information when contacted during the restricted period and make a determination of the responsibility of the Offerer/bidder pursuant to these two statutes. Certain findings of non-responsibility can result in rejection for contract award and in the event of two findings within a 4 year period, the Offerer/bidder is debarred from obtaining governmental Procurement Contracts. Further information about these requirements can be found on the Office of General Services Website at: <http://www.ogs.state.ny.us/aboutOgs/regulations/defaultAdvisoryCouncil.html>

1. Has any Governmental Entity made a finding of non-responsibility regarding the individual or entity seeking to enter into the Procurement Contract in the previous four years? (Please circle):

No Yes

If yes, please answer the next questions:

1a. Was the basis for the finding of non-responsibility due to a violation of State Finance Law §139-j (Please circle):

No Yes

1b. Was the basis for the finding of non-responsibility due to the intentional provision of false or incomplete information to a Governmental Entity? (Please circle):

No Yes

1c. If you answered yes to any of the above questions, please provide details regarding the finding of non-responsibility below.

Governmental Entity: _____

Date of Finding of Non-responsibility: _____

Basis of Finding of Non-Responsibility:

(Add additional pages as necessary)

2a. Has any Governmental Entity or other governmental agency terminated or withheld a Procurement Contract with the above-named individual or entity due to the intentional provision of false or incomplete information? (Please circle):

No

Yes

2b. If yes, please provide details below.

Governmental Entity: _____

Date of Termination or Withholding of Contract: _____

Basis of Termination or Withholding:

(Add additional pages as necessary)

C. Offerer/Bidder certifies that all information provided to the Department of Health with respect to State Finance Law §139-k is complete, true and accurate.

D. Offerer/Bidder agrees to provide the following documentation either *with their submitted bid/proposal or upon award* as indicated below:

With Bid

Upon Award

1. A completed N.Y.S Taxation and Finance Contractor Certification Form ST-220.

2. A completed N.Y.S. Office of the State Comptroller Vendor Responsibility Questionnaire (for procurements greater than or equal to \$100,000)

3. A completed State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term

(Officer Signature)

(Date)

(Officer Title)

(Telephone)

(e-mail Address)

ATTACHMENT VI

**NEW YORK STATE
VENDOR RESPONSIBILITY QUESTIONNAIRE
FOR-PROFIT BUSINESS ENTITY**

BUSINESS ENTITY INFORMATION				
Legal Business Name			EIN	
Address of the Principal Place of Business/Executive Office			Phone Number	Fax Number
E-mail		Website		
Authorized Contact for this Questionnaire				
Name:			Phone Number	Fax Number
Title			Email	
List any other DBA, Trade Name, Other Identity, or EIN used in the last five (5) years, the state or county where filed, and the status (active or inactive): (if applicable)				
Type	Name	EIN	State or County where filed	Status

I. BUSINESS CHARACTERISTICS	
1.0 Business Entity Type – Please check appropriate box and provide additional information:	
a) <input type="checkbox"/> Corporation (including	Date of
b) <input type="checkbox"/> Limited Liability Co. (LLC or PLLC)	Date Organized
c) <input type="checkbox"/> Limited Liability	Date of Registration
d) <input type="checkbox"/> Limited Partnership	Date Established
e) <input type="checkbox"/> General Partnership	Date Established County (if formed in NYS)
f) <input type="checkbox"/> Sole Proprietor	How many years in business?
g) <input type="checkbox"/> Other	Date Established
If Other, explain:	
1.1 Was the Business Entity formed in New York State? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If 'No' indicate jurisdiction where Business Entity was formed: <input type="checkbox"/> United States State _____ <input type="checkbox"/> Other Country _____	
1.2 Is the Business Entity currently registered to do business in New York State with the Department of State? Note: <i>Select 'Not Required' if the Business Entity is a Sole Proprietor or General Partnership</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required	
If 'No' explain why the Business Entity is not required to be registered in New York State.	

I. BUSINESS CHARACTERISTICS		
1.3 Is the Business Entity registered as a Sales Tax Vendor with the New York State Department of Taxation and Finance?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'No', explain and provide detail, such as "not required", "application in process", or other reason for not being registered.		
1.4 Is the Business Entity publicly traded?		<input type="checkbox"/> Yes <input type="checkbox"/> No
CIK Code or Ticker Symbol 		
1.5 Is the responding Business Entity a Joint Venture? <i>Note: If the Submitting Business Entity is a Joint Venture, also submit a questionnaire for each Business Entity comprising the Joint Venture</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
1.6 Does the Business Entity have a DUNS Number?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Enter DUNS Number		
1.7 Is the Business Entity's Principal Place of Business/Executive Office in New York State? If 'No', does the Business Entity maintain an office in New York State?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Provide the address and telephone number for one New York office.		
1.8 Is the Business Entity a New York State Certified Minority Owned Business Enterprise (MBE), Women Owned Business Enterprise (WBE), New York State Small Business or a Federally Certified Disadvantaged Business Enterprise (DBE)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>If 'Yes', check all that apply:</p> <input type="checkbox"/> New York State Certified Minority Owned Business Enterprise (MBE) <input type="checkbox"/> New York State Certified Women Owned Business Enterprise (WBE) <input type="checkbox"/> New York State Small Business <input type="checkbox"/> Federally Certified Disadvantaged Business Enterprise (DBE)		
1.9 Identify Business Entity Officials and Principal Owners. For each person, include name, title and percentage of ownership, if applicable. <i>Attach additional pages if necessary.</i>		
Name	Title	Percentage Ownership (<i>Enter 0% if not applicable</i>)
II. AFFILIATES AND JOINT VENTURE RELATIONSHIPS		
2.0 Does the Business Entity have any Affiliates? <i>Attach additional pages if necessary.</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Affiliate Name	Affiliate EIN (<i>If available</i>)	Affiliate's Primary Business Activity
Explain relationship with the Affiliate and indicate percent ownership, if applicable (enter N/A, if not applicable):		
Are there any Business Entity Officials or Principal Owners that the Business Entity has in common with this Affiliate?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Individual's Name	Position/Title with Affiliate	
2.1 Has the Business Entity participated in any Joint Ventures within the past three (3) years? <i>Attach additional pages if necessary</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Venture Name:	Joint Venture EIN (<i>If available</i>):	Identify parties to the Joint Venture:

III. CONTRACT HISTORY	
3.0 Has the Business Entity held any contracts with New York State government entities in the last three (3) years? If “Yes” attach a list including the Contract Number, Agency Name, Contract Amount, Contract Start Date, Contract End Date, and the Contract Description.	<input type="checkbox"/> Yes <input type="checkbox"/> No

IV. INTEGRITY – CONTRACT BIDDING	
Within the past five (5) years, has the Business Entity or any Affiliate	
4.0 been suspended or debarred from any government contracting process or been disqualified on any government procurement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.1 been subject to a denial or revocation of a government prequalification?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.2 been denied a contract award or had a bid rejected based upon a finding of non-responsibility by a government entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.3 had a low bid rejected on a government contract for failure to make good faith efforts on any Minority Owned Business Enterprise, Women Owned Business Enterprise or Disadvantaged Business Enterprise goal or statutory affirmative action requirements on a previously held contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.4 agreed to a voluntary exclusion from bidding/contracting with a government entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.5 initiated a request to withdraw a bid submitted to a government entity or made any claim of an error on a bid submitted to a government entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For each “Yes” answer above provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, relevant dates, the government entity involved, and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	

V. INTEGRITY – CONTRACT AWARD	
Within the past five (5) years, has the Business Entity or any Affiliate	
5.0 been suspended, cancelled or terminated for cause on any government contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.1 been subject to an administrative proceeding or civil action seeking specific performance or restitution in connection with any government contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.2 entered into a formal monitoring agreement as a condition of a contract award from a government entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For each “Yes” answer provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, relevant dates, the government entity involved, and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	

VI. CERTIFICATIONS/LICENSES	
Within the past five (5) years, has the Business Entity or any Affiliate	
6.0 had a revocation, suspension or disbarment of any business or professional permit and/or license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.1 had a denial, decertification, revocation or forfeiture of New York State certification of Minority Owned Business Enterprise, Women Owned Business Enterprise or federal certification of Disadvantaged Business Enterprise status, for other than a change of ownership?	<input type="checkbox"/> Yes <input type="checkbox"/> No

VI. CERTIFICATIONS/LICENSES	
Within the past five (5) years, has the Business Entity or any Affiliate	
For each "Yes" answer provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, relevant dates, the government entity involved, and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	

VII. LEGAL PROCEEDINGS	
Within the past five (5) years, has the Business Entity or any Affiliate	
7.0 been the subject of an investigation, whether open or closed, by any government entity for a civil or criminal violation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.1 been the subject of an indictment, grant of immunity, judgment or conviction (including entering into a plea bargain) for conduct constituting a crime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.2 received any OSHA citation and Notification of Penalty containing a violation classified as serious or willful?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.3 had a government entity find a willful prevailing wage or supplemental payment violation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.4 had any New York State Labor Law violation deemed willful?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.5 entered into a consent order with the New York State Department of Environmental Conservation, or a Federal, State or local government enforcement determination involving a violation of federal, state or local environmental laws?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.6 other than the previously disclosed: (i) Been subject to the imposition of a fine or penalty in excess of \$1,000 imposed by any government entity as a result of the issuance of citation, summons or notice of violation, or pursuant to any administrative, regulatory, or judicial determination; or (ii) Been charged or convicted of a criminal offense pursuant to any administrative and/or regulatory action taken by any government entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For each "Yes" answer provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, relevant dates, the government entity involved, and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	

VIII. LEADERSHIP INTEGRITY	
NOTE: If the Business Entity is a Joint Venture Entity, answer 'N/A – Not Applicable' to questions 8.0 through 8.4.)	
Within the past five (5) years has any individual previously identified, any other Business Entity Leader not previously identified, or any individual having the authority to sign, execute or approve bids, proposals, contracts or supporting documentation with New York State been subject to	
8.0 a sanction imposed relative to any business or professional permit and/or license?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8.1 an investigation, whether open or closed, by any government entity for a civil or criminal violation for any business related conduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8.2 an indictment, grant of immunity, judgment, or conviction of any business related conduct constituting a crime including, but not limited to, fraud, extortion, bribery, racketeering, price fixing, bid collusion or any crime related to truthfulness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8.3 a misdemeanor or felony charge, indictment or conviction for: (i) any business-related activity including but not limited to fraud, coercion, extortion, bribe or bribe-receiving, giving or accepting unlawful gratuities, immigration or tax fraud, racketeering, mail fraud, wire fraud, price fixing or collusive bidding; or (ii) any crime, whether or not business related, the underlying conduct of which related to truthfulness, including but not limited to the filing of false documents or false sworn statements, perjury or larceny?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

VIII. LEADERSHIP INTEGRITY	
NOTE: If the Business Entity is a Joint Venture Entity, answer 'N/A – Not Applicable' to questions 8.0 through 8.4.) Within the past five (5) years has any individual previously identified , any other Business Entity Leader not previously identified, or any individual having the authority to sign, execute or approve bids, proposals, contracts or supporting documentation with New York State been subject to	
8.4 a debarment from any government contracting process?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
For each "Yes" answer provide an explanation of the issue(s), the individual involved, the government entity involved, the relationship to the submitting Business Entity, relevant dates, any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	

IX. FINANCIAL AND ORGANIZATIONAL CAPACITY	
9.0 Within the past five (5) years, has the Business Entity or any Affiliates received a formal unsatisfactory performance assessment(s) from any government entity on any contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, relevant dates, the government entity involved, and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	
9.1 Within the past five (5) years, has the Business Entity or any Affiliates had any liquidated damages assessed over \$25,000?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, relevant dates, contracting party involved, the amount assessed and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	
9.2 Within the past five (5) years, has the Business Entity or any Affiliates had any liens, claims or judgments (not including UCC filings) over \$25,000 filed against the Business Entity which remain undischarged or were unsatisfied for more than 90 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the lien holder or claimant's name, the amount of the lien(s) and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	
9.3 In the last seven (7) years, has the Business Entity or any Affiliates initiated or been the subject of any bankruptcy proceedings, whether or not closed, regardless of the date of filing, or is any bankruptcy proceeding pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" provide the Business Entity involved, the relationship to the submitting Business Entity, the Bankruptcy chapter number, the Court name, and the docket number. Indicate the current status of the proceedings as "Initiated," "Pending" or "Closed." Provide answer below or attach additional sheets with numbered responses.	
9.4 During the past three (3) years, has the Business Entity and any Affiliates failed to file or pay any tax returns required by federal, state or local tax laws?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" provide the Business Entity involved, the relationship to the submitting Business Entity, the taxing jurisdiction (federal, state or other), the type of tax, the liability years, the tax liability amount the Business Entity failed to file/pay and the current status of the tax liability. Provide answer below or attach additional sheets with numbered responses.	
9.5 During the past three (3) years, has the Business Entity and any Affiliates failed to file or pay any New York State unemployment insurance returns?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" provide the Business Entity involved, the relationship to the submitting Business Entity, the years the Business Entity failed to file/pay the insurance, explain the situation and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	

IX. FINANCIAL AND ORGANIZATIONAL CAPACITY

9.6 During the past three (3) years, has the Business Entity or any Affiliates had any government audits?
If “yes” did any audit reveal material weaknesses in the Business Entity’s system of internal controls?
If “Yes”, did any audit reveal non-compliance with contractual agreements or any material disallowance (if not previously disclosed in 9.6)?

Yes No
 Yes No
 Yes No

For each “Yes” answer provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, relevant dates, the government entity involved, and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.

X. FREEDOM OF INFORMATION LAW (FOIL)

10.0 Indicate whether any information supplied herein is believed to be exempt from disclosure under the Freedom of Information Law (FOIL). Note: A determination of whether such information is exempt from FOIL will be made at the time of any request for disclosure under FOIL.

Yes No

Indicate the question number(s) and explain the basis for the claim.

Certification

The undersigned: recognizes that this questionnaire is submitted for the express purpose of assisting the State of New York or its agencies or political subdivisions in making a determination regarding an award of contract or approval of a subcontract; acknowledges that the State or its agencies or political subdivisions may in its discretion, by means which it may choose, verify the truth and accuracy of all statements made herein; and acknowledges that intentional submission of false or misleading information may constitute a felony under Penal Law Section 210.40 or a misdemeanor under Penal Law Section 210.35 or Section 210.45, and may also be punishable by a fine and/or imprisonment of up to five years under 18 USC Section 1001 and may result in contract termination.

The undersigned certifies that he/she:

- is knowledgeable about the submitting Business Entity’s business and operations;
- has read and understands all of the questions contained in the questionnaire;
- has not altered the content of the question set in any manner;
- has reviewed and/or supplied full and complete responses to each question;
- to the best of their knowledge, information and belief, confirms that the Business Entity’s responses are true, accurate and complete, including all attachments; if applicable;
- understands that New York State will rely on information disclosed in this questionnaire when entering into a contract with the Business Entity; and
- is under obligation to update the information provided herein to include any material changes to the Business Entity's responses at the time of bid/proposal submission through the contract award notification, and may be required to update the information at the request of the state's contracting entity or the Office of the State Comptroller prior to the award and/or approval of a contract, or during the term of the contract.

Signature of
Owner/Officer _____

Printed Name of Signatory _____

Title _____

Name of Business _____

Address _____

City, State, Zip _____

Sworn to before me this _____ day of _____, 20____;

_____ Notary Public

NEW YORK STATE
VENDOR RESPONSIBILITY QUESTIONNAIRE
NOT-FOR PROFIT BUSINESS ENTITY

BUSINESS ENTITY INFORMATION				
Legal Business Name			EIN	
Address of the Principal Place of Business/Executive Office			Phone Number	Fax Number
E-mail		Website		
Authorized Contact for this Questionnaire				
Name:			Phone Number	Fax Number
Title			Email	
List any other DBA, Trade Name, Other Identity, or EIN used in the last five (5) years, the state or county where filed, and the status (active or inactive): (if applicable)				
Type	Name	EIN	State or County where filed	Status

I. BUSINESS CHARACTERISTICS	
1.0 Business Entity Type – Please check appropriate box and provide additional information:	
a) <input type="checkbox"/> Corporation (including PC)	Date of
b) <input type="checkbox"/> Limited Liability Co. (LLC or PLLC)	Date Organized
c) <input type="checkbox"/> Limited Liability	Date of Registration
d) <input type="checkbox"/> Limited Partnership	Date Established
e) <input type="checkbox"/> General Partnership	Date County (if formed in
f) <input type="checkbox"/> Sole Proprietor	How many years in business?
g) <input type="checkbox"/> Other	Date Established
If Other, explain:	
1.1 Was the Business Entity formed in New York State?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'No' indicate jurisdiction where Business Entity was formed:	
<input type="checkbox"/> United States State _____	
<input type="checkbox"/> Other Country _____	
1.2 Is the Business Entity currently registered to do business in New York State with the Department of State? <i>Note: Select 'not required' if the Business Entity is a General Partnership.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required
If "No" explain why the Business Entity is not required to be registered in New York State.	
1.3 Is the Business Entity registered as a Sales Tax vendor with the New York State Department of Tax and Finance?	<input type="checkbox"/> Yes <input type="checkbox"/> No

I. BUSINESS CHARACTERISTICS		
Explain and provide detail, such as 'not required', 'application in process', or other reasons for not being registered.		
1.4 Is the Business Entity a Joint Venture? <i>Note: If the submitting Business Entity is a Joint Venture, also submit a separate questionnaire for the Business Entity comprising the Joint</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
1.5 Does the Business Entity have an active Charities Registration Number?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Enter Number: _____ If Exempt/Explain: _____ If an application is pending, enter date of application: _____		Attach a copy of the application
1.6 Does the Business Entity have a DUNS Number?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Enter DUNS Number		
1.7 Is the Business Entity's principal place of business/Executive Office in New York State? If 'No', does the Business Entity maintain an office in New York State?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Provide the address and telephone number for one New York Office.		
1.8 Is the Business Entity's principal place of business/executive office:		
<input type="checkbox"/> Owned <input type="checkbox"/> Rented Landlord Name (if 'rented') _____ <input type="checkbox"/> Other Provide explanation (if 'other') _____		
Is space shared with another Business Entity?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of other Business Entity _____		
Address _____		
City _____ State _____ Zip _____ Country _____		
1.9 Is the Business Entity a Minority Community Based Organization (MCBO)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
1.10 Identify current Key Employees of the Business Entity. Attach additional pages if necessary.		
Name	Title	
1.11 Identify current Trustees/Board Members of the Business Entity. Attach additional pages if necessary.		
Name	Title	
II. AFFILIATES AND JOINT VENTURE RELATIONSHIPS		
2.0 Does the Business Entity have any Affiliates? Attach additional pages if necessary (If no proceed to section III)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Affiliate Name	Affiliate EIN (If available)	Affiliate's Primary Business Activity
Explain relationship with the Affiliate and indicate percent ownership, if applicable (enter N/A, if not applicable):		

II. AFFILIATES AND JOINT VENTURE RELATIONSHIPS	
Are there any Business Entity Officials or Principal Owners that the Business Entity has in common with this Affiliate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Individual's Name	Position/Title with Affiliate

III. CONTRACT HISTORY	
3.0 Has the Business Entity held any contracts with New York State government entities in the last three (3) years? ? If "Yes" attach a list including the Contract Number, Agency Name, Contract Amount, Contract Start Date, Contract End Date, and the Contract Description.	<input type="checkbox"/> Yes <input type="checkbox"/> No

IV. INTEGRITY – CONTRACT BIDDING	
Within the past five (5) years, has the Business Entity or any Affiliate	
4.0 been suspended or debarred from any government contracting process or been disqualified on any government procurement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.1 been subject to a denial or revocation of a government prequalification?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.2 been denied a contract or had a bid rejected based upon a finding of non-responsibility by a government entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.3 agreed to a voluntary exclusion from bidding/contracting with a government entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.4 initiated a request to withdraw a bid submitted to a government entity or made any claim of an error on a bid submitted to a government entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For each "Yes" answer provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	

V. INTEGRITY – CONTRACT AWARD	
Within the past five (5) years, has the Business Entity or any Affiliate	
5.0 been suspended, cancelled or terminated for cause on any government contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.1 been subject to an administrative proceeding or civil action seeking specific performance or restitution in connection with any government contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.2 entered into a formal monitoring agreement as a condition of a contract award from a government entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For each "Yes" answer provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	

VI. CERTIFICATIONS/LICENSES	
6.0 Within the past five (5) years, has the Business Entity or any Affiliate had a revocation, suspension or disbarment of any business or professional permit and/or license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	

VII. LEGAL PROCEEDINGS	
Within the past five (5) years, has the Business Entity or any Affiliate	

VII. LEGAL PROCEEDINGS	
Within the past five (5) years, has the Business Entity or any Affiliate	
7.0 been the subject of an investigation, whether open or closed, by any government entity for a civil or criminal violation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.1 been the subject of an indictment, grant of immunity, judgment or conviction (including entering into a plea bargain) for conduct constituting a crime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.2 received any OSHA citation and Notification of Penalty containing a violation classified as serious or willful?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.3 had any New York State Labor Law violation deemed willful?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.4 entered into a consent order with the New York State Department of Environmental Conservation, or a federal, state or local government enforcement determination involving a violation of federal, state or local environmental laws?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.5 other than the previously disclosed: (i) Been subject to the imposition of a fine or penalty in excess of \$1,000, imposed by any government entity as a result of the issuance of citation, summons or notice of violation, or pursuant to any administrative, regulatory, or judicial determination; or (ii) Been charged or convicted of a criminal offense pursuant to any administrative and/or regulatory action taken by any government entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For each "Yes" answer provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	

VIII. LEADERSHIP INTEGRITY	
Note: If the Business Entity is a Joint Venture, answer 'N/A- Not Applicable' to questions 8.0 through 8.4.	
Within the past five (5) years has any individual previously identified, any other Key Employees not previously identified or any individual having the authority to sign execute or approve bids, proposals, contracts or supporting documentation with New York State been subject to	
8.0 a sanction imposed relative to any business or professional permit and/or license?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8.1 an investigation, whether open or closed, by any government entity for a civil or criminal violation for any business related conduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8.2 an indictment, grant of immunity, judgment, or conviction of any business related conduct constituting a crime including, but not limited to, fraud, extortion, bribery, racketeering, price fixing, bid collusion or any crime related to truthfulness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8.3 a misdemeanor or felony charge, indictment or conviction for: (i) any business-related activity including but not limited to fraud, coercion, extortion, bribe or bribe-receiving, giving or accepting unlawful gratuities, immigration or tax fraud, racketeering, mail fraud, wire fraud, price fixing or collusive bidding; or (ii) any crime, whether or not business related, the underlying conduct of which related to truthfulness, including but not limited to the filing of false documents or false sworn statements, perjury or larceny?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
8.4 a debarment from any government contracting process?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
For each "Yes" answer provide an explanation of the issue(s), the individual involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	

IX. FINANCIAL AND ORGANIZATIONAL CAPACITY	
9.0 Within the past five (5) years, has the Business Entity or any Affiliates received any formal unsatisfactory performance assessment(s) from any government entity on any contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If “Yes” provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	
9.1 Within the past five (5) years, has the Business Entity or any Affiliates had any liquidated damages assessed over \$25,000?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If “Yes” provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the contracting party involved, the amount assessed and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	
9.2 Within the past five (5) years, has the Business Entity or any Affiliates had any liens, claims or judgments over \$15,000 filed against the Business Entity which remain undischarged or were unsatisfied for more than 120 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If “Yes” provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, relevant dates, the lien holder or claimant’s name(s), the amount of the lien(s), claim(s), or judgments(s) and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	
9.3 Within the last seven (7) years, has the Business Entity or any Affiliate initiated or been the subject of any bankruptcy proceedings, whether or not closed, regardless of the date of filing, or is any bankruptcy proceeding pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If “Yes” provide the Business Entity involved, the relationship to the submitting Business Entity, the Bankruptcy Chapter Number, the Court name, the Docket Number. Indicate the current status of the proceedings as “Initiated,” “Pending” or “Closed”. Provide answer below or attach additional sheets with numbered responses.	
9.4 During the past three (3) years, has the Business Entity and any Affiliates failed to file or pay any tax returns required by federal, state or local tax laws?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If “Yes” provide the Business Entity involved, the relationship to the submitting Business Entity, the taxing jurisdiction (federal, state or other), the type of tax, the liability year(s), the Tax Liability amount the Business Entity failed to file/pay, and the current status of the Tax Liability. Provide answer below or attach additional sheets with numbered responses.	
9.5 During the past three (3) years, has the Business Entity and any Affiliates failed to file or pay any New York State unemployment insurance returns?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If “Yes” provide the Business Entity involved, the relationship to the submitting Business Entity, the year(s) the Business Entity failed to file/pay the insurance, explain the situation, and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	
9.6 During the past three (3) years, has the Business Entity or any Affiliates had any government audits? If “Yes”, did any audit reveal material weaknesses in the Business Entity’s system of internal controls If “Yes”, did any audit reveal non-compliance with contractual agreements or any material disallowance (if not previously disclosed in 9.6)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

IX. FINANCIAL AND ORGANIZATIONAL CAPACITY

For each “Yes” answer provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.

X. FREEDOM OF INFORMATION LAW (FOIL)

10.0 Indicate whether any information supplied herein is believed to be exempt from disclosure under the Freedom of Information Law (FOIL). Note: A determination of whether such information is exempt from FOIL will be made at the time of any request for disclosure under FOIL.

Yes No

Indicate the question number(s) and explain the basis for your claim.

Certification

The undersigned: recognizes that this questionnaire is submitted for the express purpose of assisting the State of New York or its agencies or political subdivisions in making a determination regarding an award of contract or approval of a subcontract; acknowledges that the State or its agencies or political subdivisions may in its discretion, by means which it may choose, verify the truth and accuracy of all statements made herein; and acknowledges that intentional submission of false or misleading information may constitute a felony under Penal Law Section 210.40 or a misdemeanor under Penal Law Section 210.35 or Section 210.45, and may also be punishable by a fine and/or imprisonment of up to five years under 18 USC Section 1001 and may result in contract termination.

The undersigned certifies that he/she:

- is knowledgeable about the submitting Business Entity’s business and operations;
- has read and understands all of the questions contained in the questionnaire;
- has not altered the content of the question set in any manner;
- has reviewed and/or supplied full and complete responses to each question;
- to the best of their knowledge, information and belief, confirms that the Business Entity’s responses are true, accurate and complete, including all attachments; if applicable;
- understands that New York State will rely on information disclosed in this questionnaire when entering into a contract with the Business Entity; and
- is under obligation to update the information provided herein to include any material changes to the Business Entity's responses at the time of bid/proposal submission through the contract award notification, and may be required to update the information at the request of the state's contracting entity or the Office of the State Comptroller prior to the award and/or approval of a contract, or during the term of the contract.

Signature of
Owner/Officer
Printed Name of
Signatory

Title

Name of Business

Address

City, State, Zip

Sworn to before me this _____ day of _____, 20____;

_____ Notary Public

**ATTACHMENT VII
Cost Proposal**

Task (check **ONE**)

NOTE: Offerors must complete a separate Cost Proposal for each Task the Offeror bids on.

_____ Evaluation of the Partnership Plan and Family Planning Expansion Programs

_____ Evaluation of the Federal-State Health Reform Partnership (F-SHRP)

This RFP will result in a fixed price contract based on the successful Offeror's Total Bid amount. Payments to the contractor will be based on satisfactory completion of deliverables, as described in Section E.5. of this RFP. Information requested below concerning hourly rates and number of hours are for informational purposes only.

The hourly rates must be inclusive of all costs including salaries, fringe benefits, administrative costs, overhead, travel, presentation costs and profit.

Include the title and composite hourly rate for each staff person that will work on the project.

The total bid price must reflect all costs for the full term of the contract.

Staff Listing <u>(list separately by title)</u>	Hourly <u>Rate</u>	X	No. Hours <u>on Project</u>	=	Total Cost <u>per Staff</u>
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Total Bid _____

Signature of Authorized Official

Date

ATTACHMENT VIII

State Consultant Services FORM A
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OSC Use Only Reporting Code: Category Code: Date Contract Approved:
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Contractor's Planned Employment
 From Contract Start Date through End of Contract Term

New York State Department of Health Contractor Name:	Agency Code 12000 Contract Number:
Contract Start Date: / /	Contract End Date: / /

Employment Category	Number of Employees	Number of Hours to be Worked	Amount Payable Under the Contract
Totals this page:	0	0	\$ 0.00
Grand Total:	0	0	\$ 0.00

Name of person who prepared this report:

Title:

Phone #:

Preparer's signature:

Date Prepared: / /

Page of
 (use additional pages if necessary)

Instructions

State Consultant Services
Form A: Contractor's Planned Employment
And
Form B: Contractor's Annual Employment Report

- Form A: This report must be completed before work begins on a contract. Typically it is completed as a part of the original bid proposal. The report is submitted only to the soliciting agency who will in turn submit the report to the NYS Office of the State Comptroller.
- Form B: This report must be completed annually for the period April 1 through March 31. The report must be submitted by May 15th of each year to the following three addresses:
1. the designated payment office (DPO) outlined in the consulting contract.
 2. NYS Office of the State Comptroller
Bureau of Contracts
110 State Street, 11th Floor
Albany, NY 12236
Attn: Consultant Reporting
or via fax to -
(518) 474-8030 or (518) 473-8808
 3. NYS Department of Civil Service
Alfred E. Smith Office Building
Albany, NY 12239
Attn: Consultant Reporting

Completing the Reports:

Scope of Contract (Form B only): a general classification of the single category that best fits the predominate nature of the services provided under the contract.

Employment Category: the specific occupation(s), as listed in the O*NET occupational classification system, which best describe the employees providing services under the contract. Access the O*NET database, which is available through the US Department of Labor's Employment and Training Administration, on-line at online.onetcenter.org to find a list of occupations.)

Number of Employees: the total number of employees in the employment category employed to provide services under the contract during the Report Period, including part time employees and employees of subcontractors.

Number of hours (to be) worked: for Form A, the total number of hours to be worked, and for Form B, the total number of hours worked during the Report Period by the employees in the employment category.

Amount Payable under the Contract: the total amount paid or payable by the State to the State contractor under the contract, for work by the employees in the employment category, for services provided during the Report Period.

ATTACHMENT IX

State Consultant Services <h1 style="margin: 0;">FORM B</h1>

OSC Use Only Reporting Code: Category Code:
--

Contractor's Annual Employment Report
 Report Period: April 1, ____ to March 31, ____

New York State Department of Health Contract Number: Contract Start Date: / / / Contractor Name: Contractor Address:	Agency Code 12000 Contract End Date: / / Description of Services Being Provided:
---	--

Scope of Contract (Chose one that best fits):

Analysis	Evaluation	Research
Training	Data Processing	Computer Programming
Other IT Consulting	Engineering	Architect Services
Surveying	Environmental Services	Health Services
Mental Health Services	Accounting	Auditing
Paralegal	Legal	Other Consulting

Employment Category	Number of Employees	Number of Hours to be Worked	Amount Payable Under the Contract
Totals this page:	0	0	\$ 0.00
Grand Total:	0	0	\$ 0.00

Name of person who prepared this report:
 Title:

Phone #:

Preparer's signature:

Date Prepared: / /

Page of
 (use additional pages if necessary)

Instructions

State Consultant Services
Form A: Contractor's Planned Employment
And
Form B: Contractor's Annual Employment Report

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Completing the Reports:

Scope of Contract (Form B only): a general classification of the single category that best fits the predominate nature of the services provided under the contract.

Employment Category: the specific occupation(s), as listed in the O*NET occupational classification system, which best describe the employees providing services under the contract. Access the O*NET database, which is available through the US Department of Labor's Employment and Training Administration, on-line at online.onetcenter.org to find a list of occupations.)

Number of Employees: the total number of employees in the employment category employed to provide services under the contract during the Report Period, including part time employees and employees of subcontractors.

Number of hours (to be) worked: for Form A, the total number of hours to be worked, and for Form B, the total number of hours worked during the Report Period by the employees in the employment category.

Amount Payable under the Contract: the total amount paid or payable by the State to the State contractor under the contract, for work by the employees in the employment category, for services provided during the Report Period.

ATTACHMENT X

NYS Taxation and Finance Form ST-220-TD

This form may be accessed electronically at:

http://www.tax.state.ny.us/pdf/2006/fillin/st/st220td_606_fill_in.pdf

ATTACHMENT XI

NYS Taxation and Finance Form ST-220-CA

This form may be accessed electronically at:

http://www.tax.state.ny.us/pdf/2006/fillin/st/st220ca_606_fill_in.pdf

**ATTACHMENT XII
SPECIAL TERMS AND CONDITIONS
PARTNERSHIP PLAN/FAMILY PLANNING EXPANSION**

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00114/2

TITLE: Partnership Plan Medicaid Section 1115 Demonstration

AWARDEE: New York Department of Health

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New York's Partnership Plan Section 1115(f) Medicaid Demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the New York Department of Health (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective October 1, 2006 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration extension is approved through September 30, 2009.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility, Benefits, and Enrollment; Cost Sharing; Delivery Systems; Family Planning Expansion Program; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluations; and Schedule of State Deliverables for the Demonstration Extension.

Additionally, four attachments have been included to provide supplementary information and guidance for specific STCs.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Partnership Plan Section 1115(f) Demonstration is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. The initial Partnership Plan demonstration was approved in 1997 to enroll most Medicaid recipients into managed care organizations (Medicaid managed care program). In 2001, the Family Health Plus program was implemented as an amendment to the Demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without children, who have income and/or assets greater than Medicaid eligibility standards. In 2002, the Demonstration was further amended to provide family planning services to women losing Medicaid eligibility and certain other adults of childbearing age (family planning expansion program).

The State's goal in implementing the Demonstration is to improve the health status of low-income New Yorkers by:

- improving access to health care for the Medicaid population;
- improving the quality of health services delivered; and
- expanding coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these STCs are part, shall apply to the Demonstration.
3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in the applicable law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy that occur after the approval date of this Demonstration, unless the provision being changed is explicitly waived under the STCs herein governing the Demonstration. For the current extension period of this Demonstration, this requirement shall also apply to all applicable regulation and policy issued by CMS with respect to the Deficit Reduction Act of 2005, signed into law on February 8, 2006, including but not limited to the documentation of citizenship requirements contained in section 1903(x) of the Social Security Act (the Act).
4. **Impact on Demonstration of Changes in Federal Law.** To the extent that a change in Federal law requires either a reduction or an increase in Federal financial participation (FFP) in expenditures under such the Demonstration, the State will adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified budget neutrality agreement would be effective upon the implementation of the change. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The State shall not be required to submit title XIX State plan amendments for changes to any populations covered solely through the Demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, family planning services covered under this Demonstration, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.
7. **Amendment Process:** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:
 - a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;
 - b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis shall include current “with waiver” and “without waiver” status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;
 - c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
 - d) If applicable, a description of how the evaluation design shall be modified to incorporate the amendment provisions.
8. **Continuation of the Demonstration.** If the State intends to continue the Demonstration beyond the period of approval granted herein the State must submit to CMS written notice of the State’s intent no later than September 30, 2008 (one year prior to the expiration date on the current section 1115(f) extension period). The written notice must include any proposed changes to the Demonstration. In addition, the State must submit to CMS a complete

application, including complete budget neutrality data, no later than February 28, 2009 (6 months prior to the expiration of the current section 1115(f) extension period).

9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.
10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.
12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.
13. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.
14. **Quality Review of Eligibility.** The State will continue to submit by December 31st of each year an alternate plan for Medicaid Eligibility Quality Control (MEQC) as permitted by Federal regulations at 42 CFR 431.812(c).
15. **Public Notice and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 FR 49249 (September 27, 1994) when any program changes to the Demonstration, including but not limited to those referenced in paragraph 6 are proposed by the State.
16. **Compliance with Managed Care Regulations.** The State must comply with the managed care regulations at 42 CFR 438 et. seq., except as expressly waived or referenced in the expenditure authorities incorporated into the STCs. Capitation rates must be developed and certified as actuarially sound in accordance with 42 CFR 438.6.
17. **Federal Funds Participation.** No Federal matching funds for expenditures for this Demonstration will be provided until the effective date identified in the Demonstration approval letter. No FFP is available for this Demonstration for Medicare Part D drugs.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

The Partnership Plan Demonstration includes three distinct components. The Medicaid managed care program provides Medicaid State Plan benefits through comprehensive managed care organizations to most recipients eligible under the State plan. Family Health Plus provides a more limited benefit package, with cost-sharing imposed, to adults with and without children with specified income and assets. Finally, family planning expansion services only are provided to men and women of childbearing age with net incomes at or below 200 percent of the Federal poverty level (FPL) who are not otherwise eligible for Medicaid or other public or private health insurance coverage that provides family planning services and to women who lose Medicaid eligibility under the Partnership Plan at the conclusion of their 60-day postpartum period.

18. **Eligibility.**

Mandatory and optional State plan groups described below are subject to all applicable Medicaid laws and regulations, except as expressly waived through the waiver authorities for this Demonstration.

Those groups described below who are made eligible for the Demonstration by virtue of the expenditure authorities expressly granted in this Demonstration are subject to Medicaid laws or regulations only as specified in the expenditure authorities for this Demonstration.

Effective October 1, 2006, the eligibility groups deleted below are no longer considered eligibility groups under the Demonstration. Both the disabled and the aged will now be eligible under the Federal-State Health Reform Partnership (F-SHRP) Demonstration (11-W-00234/2).

The criteria for Partnership Plan eligibility is as follows:

Medicaid Managed Care Program

State Plan Mandatory and Optional Groups	FPL Level and/or other qualifying criteria
Pregnant women	Up to 200 % FPL
Children under age 1	Up to 200 % FPL
Children 1 through 5	Up to 133% FPL
Children 6 through 18	Up to 100% FPL
Children 19-20	Monthly income standard (determined annually)
Adult (21-64) AFDC-related family members	Monthly income standard (determined annually)
Adults and children (0-64) receiving Supplemental Security Income (SSI) payments or otherwise disabled	Monthly income standard (determined annually)
Adults (65+)	Monthly income standard (determined annually)
Demonstration Eligible Groups	
Adults and children who were recipients of or eligible for Safety Net cash assistance but are otherwise ineligible for Medicaid	Based on Public Assistance Standard of Need in county of residence

The recipients in the categories above who live in New York City and the following counties are currently required to enroll in managed care plans:

Albany, Broome, Cattaraugus, Chautauqua, Columbia, Erie, Genesee, Greene, Herkimer, Livingston, Monroe, Nassau, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Rensselaer, Rockland, Saratoga, Suffolk, and Westchester.

Family Health Plus

State Plan Mandatory and Optional Groups	FPL Level and/or other qualifying criteria
Uninsured parents of a child under the age of 21	Gross family income up to 150% FPL and countable resources that do not exceed 150% of the medically needy income standard based on family size
Demonstration Eligible Groups	
Uninsured childless adults (19-64)	Gross household income up to 100% FPL and countable resources that do not exceed 150% of the medically needy income standard based on family size

Family Planning Expansion

Demonstration Eligible Groups
Women who lose Medicaid eligibility at the conclusion of their 60-day postpartum period
Men and women of childbearing age with net incomes at or below 200% FPL who are not otherwise eligible for Medicaid or other public or private health insurance coverage that provides family planning services

19. **Eligibility Exclusions.** Notwithstanding the eligibility criteria in paragraph 18, the following persons are excluded from the Medicaid managed care program.

Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities or residents of state certified or voluntary treatment facilities for children and youth
Patients in residential health care facilities (RHCF) at time of enrollment and residents in a RHCF who are classified as permanent
Participants in capitated long term care demonstration projects
Medicaid-eligible infants living with incarcerated mothers
Infants weighing less than 1200 grams at birth and other infants less than 6 months who meet the criteria for SSI-related categories
Individuals with access to comprehensive private health insurance if cost effective
Foster care children in the placement of a voluntary agency
Foster care children in direct care [at the option of the local Department of Social Services (LDSS)]
Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid eligible for less than six months (except for pregnant women)
Individuals receiving long-term care services through long-term home health care programs, or child care facilities (except ICF services for the developmentally disabled)
Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
Individuals placed in Office of Mental Health (OMH)-licensed family care homes
Individuals enrolled in the restricted recipient program
Individuals with a "county of fiscal responsibility" code 99 in MMIS
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (OMH in MMIS)
Individuals with a "county of fiscal responsibility" code of 98 (until program features are approved by the state and operational at the local district level to permit these individuals to voluntarily enroll in Medicaid managed care)
Youth in the care and custody of the commissioner of the Office of Family & Children Services
Individuals eligible for the family planning expansion program
Individuals under sixty-five years of age (screened and require treatment) in the Centers for Disease Control breast and/or cervical cancer early detection program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable health coverage.
Individuals who are eligible for Medicaid buy-in for the working disabled and must pay a premium

20. **Eligibility Exemptions.** Notwithstanding the eligibility criteria in paragraph 18, the following persons may not be required but may voluntarily enroll in the Medicaid managed care program.

Individuals who are HIV+
Individuals with severe and persistent mental illness and children with serious emotional disturbances except those individuals whose behavioral health benefits are provided through the Medicaid fee-for-service program.

Individuals for whom a managed care provider is not geographically accessible
Pregnant women receiving prenatal care from a provider not participating in any Medicaid MCO
Individuals with chronic medical conditions who have been under active treatment for at least six months with a sub-specialist who is not a network provider for any Medicaid MCO in the service area or whose request has been approved by the New York State Department of Health Medical Director because of unusually severe chronic care needs
Individuals with end stage renal disease (ESRD)
Residents of intermediate care facilities for the mentally retarded (ICF/MR)
Individuals with characteristics and needs similar to those residing in an ICF/MR
Individuals already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO in the service area
Individuals with a developmental or physical disability receiving services through a Medicaid home and community based services (HCBS) waiver
Individuals with a developmental or physical disability whose needs are similar to participants receiving services through a Medicaid (HCBS) waiver
Participants in the Medicaid model waiver (care-at-home) programs
Individuals whose needs are similar to participants receiving services through the Medicaid model waiver (care-at-home) programs
Residents of alcohol/substance abuse long term residential treatment programs
Homeless individuals in the shelter system (at the option of the LDSS). Note: in New York City, all homeless individuals are exempt.
Native Americans
Individuals who cannot be served by a managed care provider due to a language barrier
Individuals temporarily residing out of district
Individuals with a "county of fiscal responsibility code of 98" (OMRDD in MMIS) in counties where program features are approved by the State and operational at the local district level to permit these individuals to voluntarily enroll.

21. **Partnership Plan Benefits.** Benefits provided through this Demonstration for the Medicaid managed care, Family Health Plus, and family planning expansion programs are as follows:
- a) **Medicaid Managed Care.** Medicaid benefits are State plan benefits delivered through managed care organizations, with the exception of certain services paid for by the State on a fee-for-service basis. All benefits that Medicaid managed care enrollees may receive (regardless of delivery method) are listed in Attachment A.
 - b) **Family Health Plus.** Family Health Plus benefits must be delivered by a managed care organization. In counties where no managed care organization is available, these benefits may be provided by a commercial insurer contracted with the State. Covered services are listed in Attachment B.
 - c) **Family Planning Expansion.** Family planning services are limited to those services whose primary purpose is family planning and which are provided in a family planning setting. Procedures and services authorized under this program are outlined in Attachment C.
22. **Facilitated Enrollment.** MCO, health care provider and community-based organization facilitated enrollers will engage in those activities described in 42 CFR 435.904(d)(2), as permitted by 42 CFR 435.904(e)(3)(ii), within the following parameters:
- a) Facilitated enrollers will provide program information to applicants and interested individuals as described in 42 CFR 435.905(a).

- b) Facilitated enrollers must afford any interested individual the opportunity to apply for Medicaid without delay as required by 42 CFR 435.906.
- c) If an interested individual applies for Medicaid by completing the information required under 42 CFR 435.907(a) and (b) and 42 CFR 435.910(a) and signing a Medicaid application, that application must be transmitted to the local department of social services (LDSS) for determination of eligibility.
- d) The protocols for facilitated enrollment practices between the LDSS and the facilitated enrollers must:
 - i. Ensure that choice counseling activities are closely monitored to minimize adverse risk selection; and
 - ii. Specify that determinations of Medicaid eligibility are made solely by the LDSS.
- e) The State must ensure that all protocols and training materials developed by the State, the LDSS and MCO, health care provider and community-based organization facilitated enrollers are revised to reflect the parameters of this paragraph and are submitted to CMS for review and approval no later than December 1, 2006.

V. COST SHARING

23. Co-payments will be charged to enrollees in Family Health Plus as follows:

Service	Co-payment
Clinic services	\$5 per visit
Physician services	\$5 per visit

Service	Co-payment
Prescription Drugs <ul style="list-style-type: none"> • Brand name • Generic 	\$6 \$3
Dental services	\$5 per visit with a \$25 maximum annual cap
Diabetic supplies and smoking cessation products	\$.50
Laboratory services	\$.50
Radiology services (ordered in an ambulatory setting)	\$1
Inpatient Hospital services	\$25 per stay
Non-emergent Emergency Room services	\$3

Family Health Plus enrollees under 21 years of age or who are pregnant are exempt from these cost-sharing requirements. Additionally, the following services are exempt from these cost-sharing requirements even if provided in a setting noted above:

- Emergency services
- Family planning services and supplies
- Mental health clinics
- Chemical dependence clinics
- Psychotropic drugs
- Tuberculosis drugs

VI. DELIVERY SYSTEMS

24. **Contracts.** Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers (FQHC) shall continue in force.

Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

25. **Institutions for Mental Diseases (IMDs).** Services to Partnership Plan enrollees who are patients in IMDs will be covered only to the extent permitted under Section IX, paragraph 47.

26. **Health Services to Native American Populations.** The plan currently in place for patient management and coordination of services for Medicaid-eligible Native Americans, developed in consultation with the Indian tribes and/or representatives from the Indian health programs located in participating counties shall continue in force for this extension period.

VII. FAMILY PLANNING EXPANSION PROGRAM

27. **Duplicate Payments.** If the State provides SCHIP enrollees' coverage of family planning services under the

family planning expansion program, the State must only seek reimbursement through the SCHIP program. The State will assure CMS that no payments duplicative of Federal expenditures will be made for individuals who are enrolled in the State's Medicaid program, the State's SCHIP program, or any other Federally-funded program (i.e., title X).

The State must not use title XIX funds to pay for individuals enrolled in regular Medicaid, SCHIP, or any other Federally-funded program who seek services under the family planning Demonstration, if the State is already covering the costs of services for that individual under any of these other programs. The State will do a quarterly reconciliation to ensure that no payments duplicative of Federal expenditures will be made.

28. **Informed Consent.** The State will allow applicants the opportunity to apply for family planning services through the family planning expansion, or apply for Medicaid and/or Family Health Plus. If an applicant wants to waive his/her right to an eligibility determination for Medicaid or Family Health Plus, the State will ensure that applicants have all the information they need, both written and oral, to make a fully informed choice. The State will obtain a signature from applicants waiving their right to an eligibility determination for Medicaid or Family Health Plus.
29. **Primary Care Referral.** The State shall facilitate access to primary care services for enrollees in the family planning expansion program. The State shall submit to CMS a copy of the written materials that are distributed to the family planning expansion program participants as soon as they are available. The written materials must explain to the participants how they can access primary care services. In addition, the State must evaluate the impact of providing referrals for primary care services. This component of the evaluation must be highlighted in the evaluation design that will be submitted to CMS as specified in Section XI, paragraphs 59 (b) and 60.
30. **Eligibility Redeterminations.** The State will ensure that redeterminations of eligibility for this component of the Demonstration are conducted, at a minimum, once every 12 months. The State shall submit for CMS approval its process for eligibility redeterminations within 30 days of the date of the Demonstration award letter. The process for eligibility redeterminations shall not be passive in nature, but will require that an action be taken by the family planning expansion program recipient in order to continue eligibility for this program. The State may satisfy this requirement by having the recipient sign and return a renewal form to verify the current accuracy of the information previously reported to the State.
31. **Standardized Procedure Codes.** The State is encouraged to convert State-specific procedure codes to HIPAA-compliant codes where available, or request from CMS HIPAA-compliant codes exclusively for the State's use. Until that time, the State's use of State-specific codes for reporting data to CMS will be permitted if approved by CMS.

VIII. GENERAL REPORTING REQUIREMENTS

32. **General Financial Requirements.** The State must comply with all general financial requirements set forth in section IX.
33. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR 438 et. seq. except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.
34. **Reporting Requirements Related to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in section X.
35. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, family planning issues, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

36. **Quarterly Reports:** The State must submit progress reports in accordance with the guidelines in Attachment D no later than 60 days following the end of each quarter (March, June, September, and December of each year). The intent of these reports is to present the State's analysis and the status of the various operational areas.
37. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State must submit the draft annual report no later than January 1 after the close of each Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.
38. **Reporting Requirements Related to Family Planning Expansion.**
- a) In each annual report, the State shall report the average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth through age 1. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)
 - b) In each annual report, the State shall report the number of actual births that occur to Demonstration participants (participants include all individuals who obtain one or more covered medical family planning services through the Demonstration) each year.
 - c) The State will submit to CMS base-year fertility rates and a methodology for calculating the fertility rates no later than March 1, 2007. These rates must:
 - i. Reflect fertility rates during Base Year 2000 for women, age 19-44 years, with family incomes at or below 200 percent FPL and ineligible for Medicaid except for pregnancy.
 - ii. Be adjusted for age for all potential Demonstration participants.
 - iii. Include births paid for by Medicaid.

At the end of each Demonstration year (DY), a DY fertility rate will be determined by summing the age-specific rates using the age distribution of the Demonstration participants during that DY to weight the age-specific fertility rates, unless the State demonstrates that the age distribution is consistent with the prior DY(s). The annual age distribution categories will correspond with the base-year age-specific fertility rates.

The base-year fertility rate and the DY fertility rate will be used to calculate a measure of births averted through the Demonstration using the following formula: Births Averted = (base-year fertility rate) – (fertility rate of Demonstration participants during DY) X (number of Demonstration participants during DY). The intent of the Demonstration is to avert unintended pregnancies.

- d) No later than December 1, 2006, the State will provide to CMS for approval an appropriate methodology for ensuring the integrity of initial eligibility determinations and annual eligibility determinations of individuals covered under the family planning expansion program. The State will use this methodology to conduct reviews of the eligibility determination process on an annual basis. The State will also develop an eligibility determination error rate methodology with a corrective action plan for CMS approval.
- e) No later than December 1, 2006, a corrective action plan will be submitted to CMS outlining how the State will come into compliance with the requirements of Section VII, paragraph 27 and assure CMS that no payments duplicative of Federal expenditures will be made for individuals who are enrolled in the State's Medicaid program, the State's SCHIP program, or any other Federally-funded program (i.e., title X).

IX. GENERAL FINANCIAL REQUIREMENTS

39. **Quarterly Reports.** The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section X.

40. **Reporting Expenditures Under the Demonstration:** The following describes the reporting of expenditures under the Demonstration:
- a) In order to track expenditures under this Demonstration, New York must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All Demonstration expenditures must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). Consistent with temporary extensions granted from April 1, 2006 through September 30, 2006, reporting for Demonstration year 8 will include 18 months of expenditures to account for the time period April 1, 2005 through September 30, 2006.
 - b) New York will revise its initial 30-day submission 60 days after the completion of each quarter to report Medicaid cost settlements, pharmaceutical rebates, and to include any additional claims for the reporting period that were not available at the time of the 30-day submission. Additionally, New York's final report, filed 90 days after the completion of the quarter, contains claims that were not included in its 30-day or 60-day quarterly expenditure report submissions.
 - c) New York will report current quarter Demonstration expenditures no later than the 90-day CMS-64 submission. Quarterly cost settlements and pharmaceutical rebates relevant to the Demonstration will be allocated (using an approved methodology) to the Demonstration populations specified in subparagraph (i) and offset against current quarter waiver expenditures. Demonstration expenditures net of these cost settlement offsets will be reported on Form CMS 64.9 Waiver. Amounts offset will be identifiable in the State's supporting work papers and made available to CMS.
 - d) New York's final 90-day CMS-64 submission will contain adjustments for Demonstration expenditures initially reported on its 60-day submission as non-Demonstration expenditures on Form CMS 64.9 Base. Demonstration expenditures will be correctly reported on Forms CMS 64.9 Waiver.
 - e) For the family planning expansion component of the Demonstration, the State should report Demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:
 - i. Allowable family planning expenditures eligible for reimbursement at the State's Federal medical assistance percentage rate (FMAP) should be entered in Column (B) on the appropriate waiver sheets.
 - ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets.
 - f) Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, both the total computable and Federal share amounts that are attributable to the Demonstration must be separately reported on the CMS-64Narr.
 - g) Corrections for any incorrectly reported Demonstration expenditures for previous demonstration years must be input within 3 months of the beginning of the extension.
 - h) The State's methodology for allocating cost settlement and rebates to Demonstration populations will be

submitted to CMS for review and approval no later than January 1, 2007.

- i) For each Demonstration year, six (6) separate waiver Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below, to report expenditures for the following Demonstration populations.
 - i. **Demonstration Population 1:** TANF Child under 1 through 20 required to enroll in managed care in the counties subject to mandatory managed care enrollment as of October 1, 2006 [TANF Child].
 - ii. **Demonstration Population 2:** TANF Adults aged 21-64 required to enroll in managed care in the counties subject to mandatory managed care enrollment as of October 1, 2006 [TANF Adult].
 - iii. ~~**Demonstration Population 3:** Disabled Adults and Children 0-64 [SSI 0-64]~~
 - iv. ~~**Demonstration Population 4:** Aged or Disabled Adults [SSI 65+]~~
 - v. **Demonstration Population 5:** Safety Net Adults [Safety Net Adults]
 - vi. **Demonstration Population 6:** Family Health Plus Adults with children [FHP Adults w/Children]
 - vii. **Demonstration Population 7:** Family Health Plus Adults without children [FHP Childless Adults]
 - viii. **Demonstration Population 8:** Family Planning Expansion Adults [FP Expansion]

41. **Expenditures Subject to the Budget Neutrality Agreement.** For purposes of this section, the term “expenditures subject to the budget neutrality agreement” must include all Medicaid expenditures on behalf of individuals who are enrolled in this Demonstration as described in paragraph 40 (i) (with the exception of subparagraphs iii. and iv.) subject to limitations enumerated in this paragraph. All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.
 - a) Effective October 1, 2006, only the expenditures for Demonstration Populations 1 and 2 defined in paragraph 40(i) (“current” mandatory managed care enrollment) will be reported on Forms CMS-64.9 Waiver and/or 64.9P under this Demonstration.
 - b) Effective October 1, 2006, all expenditures for Demonstration Populations 1 and 2 as defined in paragraph 40(i) residing in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties (“new” mandatory managed care enrollment) are no longer considered expenditures subject to the budget neutrality agreement for this Demonstration and may not be reported on Forms CMS-64.9 Waiver and/or 64.9P for this Demonstration. These expenditures will be reported under the F-SHRP Demonstration (11-W-00234/2).
 - c) Effective October 1, 2006 expenditures for Demonstration Populations 3 and 4 defined in paragraph 40(i) will no longer be reported under this Demonstration. However, these eligibility groups will remain as a placeholder in the event these populations are transferred from the F-SHRP Demonstration (11-W-00234/2) back to this Demonstration. Such a transfer will only be permitted if the F-SHRP Demonstration terminates for any reason prior to September 30, 2011. The State shall follow the amendment process outlined in Section III, paragraph 7 to effectuate this transfer.
 - d) Effective October 1, 2006, Demonstration Populations 3 and 4 defined in paragraph 40(i) are no longer considered expenditures subject to the budget neutrality agreement for this Demonstration. These expenditures may not be reported on Forms CMS-64.9 Waiver and/or 64.9P under this Demonstration,

except if permitted under the provisions of paragraph 41(c). These expenditures will be reported under the F-SHRP Demonstration (11-W-00234/2), subject to the provisions of paragraph 41(c).

42. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
43. **Premium Collection Adjustment.** The State must include any Demonstration premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis and shall be reported in accordance with paragraph 40 (f).
44. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
45. **Reporting Member Months.** The following describes the reporting of member months for Demonstration populations:
 - a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 36, the actual number of eligible member months for the Demonstration Populations defined in paragraph 40(i). The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

Effective October 1, 2006, the actual number of member months for Demonstration Populations 3 and 4 as defined in paragraph 40(i) will not be used for the purpose of calculating the budget neutrality expenditure agreement, except as defined in paragraph 41(c).

Additionally, effective October 1, 2006, the actual number of member months for new mandatory managed care enrollment for Demonstration Populations 1 and 2 as defined in paragraph 40(i) will not be used for the purpose of calculating the budget neutrality expenditure agreement, subject to the limitations in paragraph 41.

To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively for up to two years as needed.
 - b) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.
 - c) For the purposes of this Demonstration, the term "Demonstration eligibles" excludes unqualified aliens and refers to the Demonstration Populations described in paragraph 40 (i). Effective October 1, 2006, "Demonstration eligibles" excludes Demonstration Populations 3 and 4, subject to paragraph 41(c), as well as portions of Demonstration Populations 1 and 2 as specified in paragraph 41(a - c).
46. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. New York must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall

reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

47. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in section X:

- a) Administrative costs, including those associated with the administration of the Demonstration; and
- b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan.
- c) FFP will be phased down for expenditures for services to a Partnership Plan enrollee age 21 through 64 residing in an Institution for Mental Diseases for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days. The FFP match rate will be phased down as follows:

Demonstration Period	Allowable Portion of Expenditures
October 1, 2006 – September 30, 2007	100%
October 1, 2007 – September 30, 2008	50%
October 1, 2008 – September 30, 2009	0%

- d) FFP will be provided for the Family Planning Expansion Program as described in paragraph 48.

48. **Extent of Federal Financial Participation for Family Planning Expansion Program.** CMS shall provide FFP for CMS-approved services (including prescriptions) provided to men and women under the family planning expansion program as follows, subject to the restrictions outlined in Attachment C:

- a) For services whose primary purpose is family planning (i.e., contraceptives and sterilizations), FFP will be available at the 90 percent matching rate. Procedure codes for office visits, laboratory tests, and certain other procedures must carry a diagnosis that specifically identifies them as family planning services. The State must be able to affirmatively justify that these services meet the criteria for the 90 percent Federal matching rate. A “Y” indicator override on a claim does not meet this affirmative justification. Such claims may not be considered family planning services and are not eligible for FFP at the 90 percent matching rate.
- b) Notwithstanding subparagraph (a) above, CMS will only provide FFP at the 90 percent match rate for expenditures made for family planning services rendered without specific procedure codes at clinics licensed under Article 28 of the New York Public Health Law through June 30, 2007. At that time, the State will have completed its efforts to obtain and require procedure code reporting from these centers as part of its effort to accurately calculate its clinic upper payment limit.

On July 1, 2007, FFP will no longer be provided for services rendered without procedure codes. In order to continue claiming FFP at the 90 percent match rate for family planning services rendered by clinics licensed under Article 28 of the New York Public Health Law, Attachment C shall be revised in accordance with the amendment process outlined in Section III, paragraph 7.

- c) The following prescription drug types/classes are not provided for the primary purpose of family planning and are not eligible for FFP under this Demonstration:
 - i. Hormone Replacement Therapy;
 - ii. Fertility Agents;
 - iii. Ovulation Inducing Agents;
 - iv. Agents for treatment of Endometriosis;
 - v. Agents for treatment of Endometrial Hyperplasia;
 - vi. Agents for treatment of Uterine Bleeding;
 - vii. Agents for treatment of Amenorrhea; and
 - viii. Prenatal Vitamins.

- d) Family planning-related services reimbursable at the FMAP rate are defined as those services generally performed as part of or as follow-up to a family planning service for contraception or sterilization. Such services are provided because a “family planning-related” problem was identified and/or diagnosed during a routine or periodic family planning visit. However, these services performed in an ambulatory surgery center/facility, a special procedure room/suite, an emergency room, an urgent care center, or a hospital setting are not covered under the Demonstration as family planning-related services.
- e) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for sexually transmitted infections as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. Subsequent treatment would be paid for at the applicable Federal matching rate for New York. For testing or treatment not associated with a family planning visit, no FFP will be available.
- f) CMS will provide FFP at the appropriate 50 percent administrative match rate for general administration costs, such as, but not limited to, claims processing, eligibility assistance and determinations, outreach, program development, and program monitoring and reporting.

49. **Medicare Part D Drugs.** No FFP is available for this Demonstration for Medicare Part D drugs.

50. **Sources of Non-Federal Share.** The State certifies that matching the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds shall not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

- a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

51. **State Certification of Funding Conditions.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

- a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.
- b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State’s claim for Federal match.
- d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

52. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

X. MONITORING BUDGET NEUTRALITY

53. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Budget neutrality limits for Demonstration years 1 through 8, as established by previously approved STCs [and Section IX, paragraph 40(a)], remain in effect for the Demonstration extension period. The data supplied by the State to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

54. **Risk.** New York shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles under this budget neutrality agreement, but not for the number of Demonstration eligibles in each of the groups. By providing FFP for all Demonstration eligibles, New York shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing New York at risk for the per capita costs for Demonstration eligibles under this agreement, CMS assures that Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

55. **Demonstration Populations Used to Calculate Budget Neutrality Cap.** The following Demonstration populations are used to calculate the budget neutrality cap subject to the limitations outlined in paragraph 41 and are incorporated into the following eligibility groups (EGs):

- a) **Eligibility Group 1:** TANF Children under age 1 through 20 required to enroll in managed care in the counties subject to mandatory managed care enrollment as of October 1, 2006 (Demonstration Population 1)
- b) **Eligibility Group 2:** TANF Adults aged 21-64 required to enroll in managed care in the counties subject to mandatory managed care enrollment as of October 1, 2006 (Demonstration Population 2)
- c) **Eligibility Group 3:** Disabled Adults and Children age 0-64 (Demonstration Population 3)
- d) **Eligibility Group 4:** Aged or Disabled Adults (Demonstration Population 4)
- e) **Eligibility Group 5:** FHPlus Adults with children (Demonstration Population 6)

56. **Budget Neutrality Expenditure Cap:** The following describes the method for calculating the budget neutrality expenditure cap for the Demonstration:

- a) For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each EG described in paragraph 55 as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under paragraph 45, except as defined in paragraph 45(c), for each EG, times the appropriate estimated per member per month (PM/PM) costs from the table in subparagraph (iii) below. Should EGs 3 and 4 be incorporated into the budget neutrality expenditure cap, as outlined in paragraph 41, the PMPM costs may be revised.
 - ii. The PM/PM costs in subparagraph (iii) below are net of premiums paid by Demonstration eligibles.

- iii. The PM/PM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility groups subject to the budget neutrality agreement under this Demonstration are specified below. In addition, the PM/PM cost for each EG in Demonstration year 9 has been increased by the appropriate growth rate included in the President's Federal fiscal year 2007 budget for DYs 10 and 11, as outlined below.

Eligibility Group	Growth Rate	DY 09 (10/1/06 – 9/30/07)	DY 10 (10/1/07 – 9/30/08)	DY 11 (10/1/08 – 9/30/09)
TANF Children under age 1 through 20	6.7%	\$482.15	\$514.58	\$549.19
TANF Adults 21-64	6.6%	\$661.56	\$705.21	\$751.73
Disabled Adults and Children 0 – 64	6.8%	\$1835.66	\$1960.91	\$2094.70
Adults 65 +	5.8%	\$1842.78	\$1950.35	\$2064.19

Eligibility Group	Growth Rate	DY 09 (10/1/06 – 9/30/07)	DY 10 (10/1/07 – 9/30/08)	DY 11 (10/1/08 – 9/30/09)
FHPlus Adults with Children	6.6%	\$516.43	\$550.50	\$586.82

- iv. The annual budget neutrality expenditure cap for the Demonstration as a whole is the sum of the projected annual expenditure caps for each EG calculated in subparagraph (i) above.
- b) The overall budget neutrality expenditure cap for the 3-year demonstration period is the sum of the annual budget neutrality expenditure caps calculated in subparagraph (a) (iv) above for each of the 3 years. The Federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the State may receive for expenditures on behalf of Demonstration populations and expenditures described in paragraph 40 (i) during the Demonstration period.

57. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Expenditure Cap Definition	Percentage
Year 9	Budget neutrality expenditure cap plus	1 percent
Years 9 and 10	Combined budget neutrality expenditure caps plus	0.5 percent
Years 9 through 11	Combined budget neutrality expenditure caps plus	0 percent

58. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period the overall budget neutrality expenditure cap has been exceeded, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XI. EVALUATION OF THE DEMONSTRATION

59. **State Must Separately Evaluate Components of the Demonstration.** As outlined in subparagraphs (a) and (b), the outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the State met the Demonstration goal, with recommendations for future efforts regarding both components. The State must submit to CMS for approval a draft evaluation design no later than January 1, 2007. The evaluation must outline and address evaluation questions for both of the following components:
- a) **The Partnership Plan.** At a minimum, the draft design must include a discussion of the goals, objectives, and evaluation questions specific to the entire Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the

Demonstration shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

- b) **Family Planning Expansion.** The draft design must include a discussion of the goals, objectives and evaluation questions specific to this component of the Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the family planning expansion program, particularly among the target family planning population, during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the family planning expansion program shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation. The report should also include an integrated presentation and discussion of the specific evaluation questions (including those that focus specifically on the target population for the family planning program) that are being tested. At a minimum, the following data elements will be included in the measurement methodology:

Measure	Number	Percentage Change
Enrollment		
Averted Births		
Family Planning Patients Receiving a Clinical Referral for Primary Care	(estimate can be based on a sample)	

60. **Final Evaluation Plan and Implementation.** CMS shall provide comments on the draft designs within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 59, within 60 days of receipt of CMS comments. The State must implement the evaluation designs and report its progress on each in the quarterly reports. The State must submit to CMS a draft evaluation report 120 days prior to the expiration of the Demonstration. CMS shall provide comments within 60 days of receipt of the report. The State must submit the final report prior to the expiration date of the Demonstration.
61. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the Demonstration, the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS.

XII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date - Specific	Deliverable	STC Reference
12/1/2006	Submit Revised Facilitated Enrollment Protocols and Training Materials for Review	Section IV, paragraph 22
11/1/2006	Submit Process for Eligibility Redeterminations for Family Planning Expansion Program	Section VII, paragraph 30
12/1/2006	Submit Methodology for Monitoring Family Planning Initial Eligibility Determinations and Annual Redeterminations	Section VIII, paragraph 38
12/1/2006	Submit Corrective Action Plan for Duplicate Family Planning Expansion Program Payments	Section VIII, paragraph 38
1/1/2007	Submit Cost Settlement and Rebate Allocation Methodology	Section IX, paragraph 40
1/1/2007	Submit Draft Evaluation Plan, including Evaluation Designs for the Partnership Plan and Family Planning	Section XI, paragraph 59

	Expansion	
3/1/2007	Submit Base-year Fertility Rates for Family Planning Expansion Program	Section VIII, paragraph 38
7/1/2007	Submit Amendment to Attachment C to reflect updated family planning procedure codes	Section IX, paragraph 48
9/30/2008	Written Notice to CMS of Intent to Continue Demonstration	Section III, paragraph 8
2/28/2009	Submit Demonstration Application [1115(a)]	Section III, paragraph 8
6/30/2009	Submit Draft Evaluation Report, which includes preliminary analysis and recommendations related to the Partnership Plan and Family Planning Expansion	Section XI, paragraph 60
9/30/2009	Submit Final Evaluation Report	Section XI, paragraph 60

	Deliverable	STC Reference
Annual	By January 1st - Draft Annual Report	Section VIII, paragraph 37
	By December 31 st – Annual MEQC Program Report	Section III, paragraph 14
Quarterly		
	Quarterly Operational Reports	Section VIII, paragraph 36
	CMS-64 Reports	Section IX, paragraph 40
	Eligible Member Months	Section IX, paragraph 45

ATTACHMENT A

Medicaid Managed Care Benefits

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21 only)
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services
Dental services
Physical and occupational therapy
Speech, hearing and language therapy
Prescription drugs, over-the-counter drugs and medical supplies
Durable medical equipment including prosthetic and orthotic devices, hearing aids and prescription shoes
Vision care services including eyeglasses
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
Nursing facility services
Personal care services
Case management services
Hospice care services
TB-related services
Inpatient and outpatient behavioral health services (mental health and chemical dependence services)
Emergency medical services including emergency transportation
Adult day care
Personal Emergency Response Services (PERS)
Renal dialysis
Home and Community Based Services waivers (HCBS)
Care at Home Program (OMRDD)
Non-emergency transportation
Experimental or investigational treatment (covered on a case by case basis)

ATTACHMENT B

Family Health Plus Benefits

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services (covered for 40 visits in lieu of hospitalization, plus 2 post-partum visits for high-risk women)
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21 only)
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services
Dental services (optional)
Physical and occupational therapy (20 visits annually)
Speech therapy (for conditions amenable to clinical improvement within a 2-month period)
Prescription drugs, diabetic supplies and smoking cessation products
Durable medical equipment including prosthetic and orthotic devices and hearing aids
Vision care services including eyeglasses
Nursing facility services
Hospice care services
TB-related services, except Directly Observed Therapy
Behavioral health services (mental health and chemical dependence services), limited to 60 outpatient visits combined and 30 inpatient days combined
Emergency medical services including emergency transportation
Renal dialysis
Experimental or investigational treatment (covered on a case by case basis)

ATTACHMENT C

Family Planning Expansion Program Procedures and Services

Amendments to this Attachment may be made consistent with Section III, paragraph 7.

The following diagnosis codes not paired with a procedure code may be considered family planning services only when rendered in clinics licensed under Article 28 of the New York Public Health Law through June 30, 2007:

V25.xx

The following procedure codes are considered family planning services as noted below:

Code	Description	90% FFP	90% FFP with V25
11975	Norplant – implant	X	
11976	Norplant – implant removal	X	
11977	Norplant - implant removal with reinsertion	X	
36415	Collection of venous blood by venipuncture		X
36416	Drawing blood, capillary		X
55250	Vasectomy, unilateral or bilateral (separate procedure)	X	
55450	Ligation (percutaneous) of vas deferens, unilateral or bilateral	X	
57170	Diaphragm or cervical cap – fitting with instructions		X
58300	IUD insertion	X	
58301	IUD removal	X	
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants		X
58600	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	X	
58615	Occlusion of fallopian tube(s) by device, vaginal or suprapubic approach	X	
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transaction)	X	
58671	Laparoscopy, surgical; with occlusion of oviducts by device	X	
71010	X-rays, prep for sterilization		X
71015	X-rays, prep for sterilization		X
81000	Urinalysis by dip stick or tablet reagent		X
81001	Urinalysis; automated with microscopy		X
81002	Urinalysis; non-automated without microscopy		X
81003	Urinalysis; automated without microscopy		X
81007	Urinalysis; bacteriuria screen, by non-culture technique, commercial kit		X
81025	Urine pregnancy test		X
82105	Alpha fetoprotein; serum		X
82465	Cholesterol, serum or whole blood, total		X
84702	HCG quantitative		X
84703	HCG qualitative		X
85013	Blood count; spun microhematocrit		X

ATTACHMENT C
Family Planning Expansion Program Procedures and Services

Code	Description	90% FFP	90% FFP with V25
85014	Blood count; other than spun hematocrit		X
85021	Blood count; hemogram, automated		X
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)		X
86592	Syphilis test, qualitative		X
86593	Syphilis test, quantitative		X
86631	Chlamydia antibody		X
86689	HTLV or HIV antibody		X
86694	Herpes simplex, non-specific type test		X
86695	Herpes simplex, type 1		X
86696	Herpes simplex, type 2		X
86701	HIV – 1		X
86702	Antibody HIV-2		X
86703	HIV – 1 & 2		X
86762	Rubella antibody		X
86781	Treponema pallidum antibody		X
87070	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates		X
87081	Culture, bacterial, screening only, for single organisms		X
87086	Culture, bacterial; quantitative colony count, urine		X
87102	Knickers test for yeast		X
87110	Culture, Chlamydia		X
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types		X
87207	Smear, primary source, with interpretation, special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)		X
87210	Smear, primary source, with interpretation, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites		X
87252	Virus isolation; tissue culture inoculation, observation, and presumptive		X
87254	Virus isolation; centrifuge enhanced (shell vial) technique		X
87270	Chlamydia trachomatis AGIF		X
87273	Herpes simplex, type 2		X
87274	Herpes simplex, type 1		X
87285	Treponema pallidum		X
87320	Infectious agent antigen detection by enzyme immunoassay technique, qualitative		X
87390	Chlamydia trachomatis		X
87391	HIV – 2		X
87430	HIV – 1		X
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Direct probe technique.		X

ATTACHMENT C

Family Planning Expansion Program Procedures and Services

Code	Description	90% FFP	90% FFP with V25
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Amplified probe technique.		X
87492	Chlamydia trachomatis, quantification		X
87528	Herpes simplex virus, direct probe technique		X
87529	Herpes simplex virus, amplified probe technique		X
87530	Herpes simplex virus, quantification		X
87534	HIV-1, direct probe technique		X
87535	HIV-1, amplified probe technique		X
87536	HIV-1, quantification		X
87537	HIV-2, direct probe technique		X
87538	HIV-2, amplified probe technique		X
87539	HIV-2, quantification		X
87590	Neisseria gonorrhea, direct probe technique		X
87591	Neisseria gonorrhea, amplified probe technique		X
87800	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms		X
87810	Trachomatis		X
87850	Neisseria gonorrhea		X
88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician (Use 88141 in conjunction with 88142-88154, 88164-88167, 88174-88175)		X
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision		X
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision		X
88148	Cytopathology, screening by automated system with manual rescreening under physician supervision		X
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision		X
88152	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision		X
88153	Cytopathology, slides, cervical or vaginal; with manual screening & rescreening under physician supervision		X
88154	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision		X
88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (Use 88155 in conjunction with 88142-88154, 88164-88167, 88174-88175)		X
88160	Cytopathology, smears, any other source; screening and interpretation		X
88162	Cytopathology, smears, any other source; extended study (over 5 slides and/or multiple stains)		X

ATTACHMENT C

Family Planning Expansion Program Procedures and Services

Code	Description	90% FFP	90% FFP with V25
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision		X
88165	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision		X
88166	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision		X
88167	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision		X
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision		X
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision		X
89310	Semen motility and count (not including hunher test)		X
89320	Semen analysis complete (volume, count, motility, and differential)		X
90772	Therapeutic or diagnostic injection; subcutaneous or intramuscular		X
93000	EKG performed in prep for tubal ligation		X
93005	EKG performed in prep for tubal ligation		X
93010	EKG performed in prep for tubal ligation		X
93040	EKG performed in prep for tubal ligation		X
93041	EKG performed in prep for tubal ligation		X
93042	EKG performed in prep for tubal ligation		X
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory		X
99001	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory		X
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed		X
99070	Supplies and materials (except spectacles), provided by the physician which are not included in the office visit		X
99201	Office or other outpatient visit – new patient		X
99202	Office or other outpatient visit – new patient		X
99203	Office or other outpatient visit – new patient		X
99204	Office or other outpatient visit – new patient		X
99205	Office or other outpatient visit – new patient		X

ATTACHMENT C

Family Planning Expansion Program Procedures and Services

Code	Description	90% FFP	90% FFP with V25
99211	Office or other outpatient visit – established patient		X
99212	Office or other outpatient visit – established patient		X
99213	Office or other outpatient visit – established patient		X
99214	Office or other outpatient visit – established patient		X
99215	Office or other outpatient visit – established patient		X
99241	Office consultation - new or established patient		X
99242	Office consultation - new or established patient		X
99243	Office consultation - new or established patient		X
99244	Office consultation - new or established patient		X
99245	Office consultation - new or established patient		X
A4261	Cervical cap contraceptive	X	
A4266	Diaphragm kit	X	
A4267	Condom, male	X	
A4268	Condom, female	X	
A4269	Spermicidal foam, contraceptive jelly	X	
J1055	Injection, Medroxyprogesterone Acetate for contraceptive use, 150mg (Depo-Provera – 150mg/ml)	X	
J1056	Injection, Medroxyprogesterone Acetate/Estradiol Cypionate, 5mg/25mg (Lunelle)	X	
J7300	Intrauterine copper contraceptive	X	
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52mg	X	
J7303	Contraceptive supply, hormone containing vaginal ring	X	
J7304	Contraceptive supply, hormone containing vaginal patch	X	
Z2351	Basal Thermometer		X

ATTACHMENT D
Quarterly Program Report Guidelines

Under Section VII, paragraph 42 of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Partnership Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 1 (10/1/06 - 9/30/06)

Federal Fiscal Quarter: 4/2007 (7/07 - 9/07)

Introduction:

Information describing the goal of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information:

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0”.

Enrollment Counts

Note: Enrollment counts should be person counts, not participant months

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	No. Voluntary Disenrolled in current Quarter	No. Involuntary Disenrolled in current Quarter
Population 1 – TANF Child under 1 through 20 in mandatory MC counties as of 10/1/06			
Population 2 - TANF Adults aged 21-64 in mandatory MC counties as of 10/1/06			
Population 3 – Safety Net Adults			
Population 4 - Family Health Plus Adults with children			
Population 5 - Family Health Plus Adults without children			

Voluntary Disenrollments:

Cumulative Number of Voluntary Disenrollments Within Current Demonstration Year:

Reasons for Voluntary Disenrollments:

Involuntary Disenrollments:

Cumulative Number of Involuntary Disenrollments Within Current Demonstration Year:

Reasons for Involuntary Disenrollments:

ATTACHMENT D
Quarterly Program Report Guidelines

Outreach/Innovative Activities:

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Developments/Issues:

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

Consumer Issues:

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback received from the MCARP and other consumer groups.

Quality Assurance/Monitoring Activity:

Identify any quality assurance/monitoring activity in current quarter.

Family Planning Expansion Program:

Identify all significant program developments/issues/problems that have occurred in the current quarter, including the required data and information under Section VIII, paragraph 38, including enrollment data for both the extension and expansion programs.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS:

ATTACHMENT XIII

EVALUATION PLAN

New York Department of Health

Partnership Plan Medicaid Section 1115 Demonstration

Start Date of Demonstration Extension: October 1, 2006
End Date of Demonstration Extension: September 30, 2009

As a component of the Special Terms and Conditions (STCs) for the Partnership Plan Medicaid Section 1115 Demonstration (No. 11-W-00114/2), the New York State Department of Health (DOH) hereby submits this draft evaluation plan for approval to the Centers for Medicare and Medicaid Services (CMS).

This evaluation plan will assess the degree to which the Demonstration goals have been achieved and/or key activities have been implemented. The evaluation plan includes a discussion of the Demonstration's major goals and activities, evaluation questions, and measures and data that will be used in the evaluation.

In accordance with the Special Terms and Conditions for the Demonstration extension, the State will conduct two evaluations during the extension period: one for the Family Planning Expansion program and one for the Demonstration extension as a whole. This evaluation plan incorporates both evaluation components even though in practice they will be conducted independently. The outcomes from each evaluation component will be integrated into one programmatic summary that examines the degree to which the State met the Demonstration goals. The final summary report will include recommendations for future efforts regarding both the Partnership Plan and Family Planning Expansion programs.

The New York State Department of Health received technical assistance from a health care management consulting and research firm to prepare this evaluation plan. The DOH will select and contract with an independent outside vendor for completion of the evaluations described above. The DOH will be responsible for the quarterly and annual reporting requirements.

OVERVIEW OF THE DEMONSTRATION

In July 1997, New York State received approval from the Health Care Financing Administration (HCFA) for its Partnership Plan Section 1115 Demonstration. The State's goal in implementing the Demonstration was to improve the health status of low income New Yorkers by improving access to health care in the Medicaid program, improving the quality of health services delivered, and expanding coverage to additional low income New Yorkers.

Through the original Demonstration, the State implemented a mandatory Medicaid managed care program in counties with sufficient managed care capacity and the infrastructure to manage the enrollment processes essential to a mandatory program. The Demonstration also enabled the extension of coverage to certain individuals who would otherwise be without health insurance.

The initial Demonstration was approved in 1997 to enroll most Medicaid recipients into managed care organizations (MCOs). In 2001, the Family Health Plus program (FHP), implemented as an amendment to the Demonstration, began providing comprehensive health coverage to low-income uninsured adults (with and without children) that have income and/or assets greater than Medicaid eligibility standards. In 2002, the Demonstration was further amended to provide family planning services to women losing

Medicaid eligibility as well as certain other adults of childbearing age.

With the original Demonstration and subsequent amendments, the Partnership Plan Demonstration includes three components:

- A Medicaid managed care program providing Medicaid State Plan benefits through comprehensive managed care organizations to most recipients eligible under the State plan;
- A Family Health Plus program providing a more limited benefit package, with cost-sharing imposed, to adults with and without children with specified income and assets; and
- A Family Planning Expansion program provided to men and women of childbearing age with net incomes at or below 200 percent of the federal poverty level (FPL) and to women who lose Medicaid eligibility under the Partnership Plan at the conclusion of their 60-day postpartum period.

With CMS approval extending the Demonstration for an additional three years, New York State is planning to commission evaluations for the Partnership Plan and the Family Planning Expansion program to determine the degree to which the State has added to the successes that it has already achieved with the Partnership Plan Demonstration.

Goals and Major Activities

The primary goals of the Partnership Plan Demonstration are to increase access, improve quality, and expand coverage to low income New Yorkers. In the years since initial approval of its Partnership Plan Demonstration, New York has made significant progress in meeting these goals.

Specifically, the Demonstration will allow the continued eligibility for the managed care program, Family Health Plus program, and the Family Planning Expansion Program, as follows:¹

Medicaid Managed Care Program

State Plan Mandatory and Optional Groups	FPL Level and/or other qualifying criteria
Pregnant women	Up to 200 % FPL
Children under age 1	Up to 200 % FPL
Children 1 through 5	Up to 133% FPL
Children 6 through 18	Up to 100% FPL
Children 19-20	Monthly income standard determined annually
Adult (21-64) AFDC-related family members	Monthly income standard determined annually
Demonstration Eligible Groups	
Adults and children who were recipients of or eligible for Safety Net cash assistance but are otherwise ineligible for Medicaid	Based on Public Assistance Standard of Need in county of residence

Family Health Plus

State Plan Mandatory and Optional Groups	FPL Level and/or other qualifying criteria
Uninsured parents of a child under the age of 21	Gross family income up to 150% FPL and countable resources that do not exceed 150% of the medically needy income standard based on family size
Demonstration Eligible Groups	

¹ Subject to exclusions and exemptions as outlined in the STCs

Uninsured childless adults (19-64)	Gross household income up to 100% FPL and countable resources that do not exceed 150% of the medically needy income standard based on family size
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Family Planning Expansion Program

Demonstration Eligible Groups
Women who lose Medicaid eligibility at the conclusion of their 60-day postpartum period
Men and women of childbearing age with net incomes at or below 200% FPL who are not otherwise eligible for Medicaid or other public or private health insurance coverage that provides family planning services

TECHNICAL APPROACH

As noted above, the primary goals of the Partnership Plan Demonstration are to increase access, improve quality, and expand coverage to low income New Yorkers. To accomplish these goals, the Demonstration includes several key activities including managed care enrollment, Family Health Plus enrollment, and Family Planning Expansion Program enrollment. This evaluation plan will assess the degree to which the key goals of the Demonstration have been achieved and/or the key activities of the Demonstration have been implemented.

Evaluation Plan Approach

The process of designing the evaluation plan first involved identifying and documenting the Demonstration’s key goals and activities, which were included in the State’s Demonstration extension proposal and the Special Terms and Conditions.

With key goals and activities identified, the process of designing the evaluation plan involved selecting several evaluation questions that correspond to each of the major Demonstration goals and activities. The evaluation itself will seek to answer the evaluation questions, which in turn will assess the degree to which the Demonstration has been effective in implementing the key activities identified, directly achieving the goals of the Demonstration, or both.

The specific evaluation questions to be addressed by the evaluation were based on the following criteria:

- 1) Potential for improvement, consistent with the key goals of the Demonstration;
- 2) Potential for measurement, including (where possible and relevant) baseline measures that can help to isolate the effects of Demonstration initiatives and activities over time; and
- 3) Potential to coordinate with the DOH’s ongoing performance evaluation and monitoring efforts.

Once research questions were selected to address the Demonstration’s major program goals and activities, specific variables and measures were then identified to correspond to each research question. Finally, a process was developed for identifying data sources that are most appropriate and efficient in answering each of the evaluation questions.

The evaluation team will use all available data sources. The timing of data collection periods will vary depending on the data source. Enrollment data will be collected monthly, provider network data quarterly, QARR/HEDIS data annually and CAHPS data every two years. For this three year period, the evaluation team will have two years of QARR data (2007 and 2008) and one year of CAHPS (2008) data.

Analysis Plan

While the Demonstration seeks to generate cost savings and promote quality care, observed changes may be attributed to the Demonstration itself and/or external factors, including other State- or national-level policy or market changes or trends. The evaluation team will develop a theoretical framework depicting how specific Demonstration goals, tasks, and activities are causally connected. This theoretical framework, which may include a logic model, will incorporate any known or possible external influences to the extent possible (such as policy changes or market shifts) and their potential interactions with the Demonstration's goals and activities.

The theoretical framework will be used as a reference for the evaluation team in isolating the degree to which the Demonstration is associated with observed changes in relevant outcomes. Specifically, the evaluation team will seek to isolate the effects of the Demonstration on the observed outcomes in several ways:

- 1) To the extent possible, the evaluation team will gather and describe credible contextual evidence that attempts to isolate the Demonstration's contribution to any observed effects as well as describe the relative contributions of other factors influencing the observed effects. This will include documenting any relevant legal, regulatory, or policy changes or other trends – including the sequence, scope, and duration of such changes – at both a State and national level that are likely to influence the observed outcomes.
- 2) Where possible and relevant, the evaluation will incorporate baseline measures for each of the selected variables included in the evaluation. Data for each of the targeted variables and measures will be collected regularly so that changes in outcome measures and variables can be observed on a longitudinal basis.
- 3) The evaluation will compare rates of performance and measures with State and national benchmarks, where relevant and feasible. Incorporating benchmark measures will allow for external comparisons of Demonstration measures to State and national trends, further isolating the impacts of the Demonstration by controlling for external factors influencing the observed effects.

The evaluation features described above (analysis of qualitative contextual information, the use of baseline measures, ongoing data collection, and benchmarking) represent quasi-experimental means by which the evaluation team will determine the effects of the Demonstration. Evaluation conclusions will include key findings associated with individual research questions addressed as well as integrated information combining the results of individual evaluation questions to make broad conclusions about the effects of the Demonstration as a whole.

In addition, the evaluation will include specific recommendations of best practices and lessons learned that can be useful for DOH, other States, and CMS. Moreover, to the extent possible, the evaluation team will integrate and/or compare evaluation conclusions and recommendations to previous studies or evaluations of relevance.

The DOH will have a contract with an EQRO to conduct the federally-required review of Managed Care Entities (MCE) as defined in 42 CFR 438 Subpart E. As the expansion of managed care to selected populations and counties is an important component of this Demonstration, the findings of EQRO activities and ongoing internal monitoring of managed care activities will be made available, as necessary, to assist the vendor selected to conduct the evaluations and write the interim and final reports.

PARTNERSHIP PLAN: EVALUATION GOALS, ACTIVITIES, MEASURES, AND DATA

This section describes the evaluation plan's key goals, activities, evaluation questions, measures/variables, and data sources related to the Partnership Plan.

GOAL 1: MANAGED CARE ENROLLMENT

Goal

Goal 1 of the Demonstration is to continue managed care enrollment in New York's Medicaid program.

Activity

To achieve Goal 1, the Demonstration will continue managed care enrollment in the Medicaid program.

Key Evaluation Questions

1. How many Medicaid beneficiaries were enrolled in Medicaid managed care as a result of the Demonstration?
 - *Outcome measures and variables:* Number of beneficiaries enrolled in managed care organizations, by beneficiary type, age category, and county.

Data Sources

- Medicaid Management Information Systems including EMedNY Data Warehouse (MMIS)

GOAL 2: IMPROVING HEALTH CARE ACCESS

Goal

Goal 2 of the Demonstration is to improve health care access for Medicaid beneficiaries in New York.

Activities

To achieve Goal 2, the State will continue to work with and monitor participating managed care organizations to ensure the adequacy of both primary and specialty networks for Medicaid managed care beneficiaries and assure that beneficiaries are able to access these services.

Key Evaluation Questions

1. To what extent has the Demonstration improved access to primary care services?
 - *Outcome measures and variables:* Physician participation in Medicaid managed care organizations, by specialty and county; number of primary care visits per member per month (PMPM); appropriate HEDIS/QARR access measures; appropriate CAHPS measures.
2. To what extent has the Demonstration improved access to specialty care services?
 - *Outcome measures and variables:* Physician participation in Medicaid managed care plans, by specialty and county; appropriate CAHPS measures.

Data Sources

- MMIS
- DOH Administrative Data
- Quality Assurance Reporting Requirements (QARR)
- Consumer Assessment of Health Plans Survey (CAHPS)

New York collects annual data known as the Quality Assurance Reporting Requirements (QARR). The resulting reports are entitled *New York State Managed Care Plan Performance* and are published annually. These reports contain information on managed care quality, access, utilization, and member satisfaction for the health plans that serve Medicaid managed care enrollees.

GOAL 3: IMPROVING QUALITY OF CARE

Goal

Goal 3 of the Demonstration is to improve the quality of care for Medicaid beneficiaries.

Activities

To achieve Goal 3, the State will continue to work with and monitor participating managed care organizations to ensure the adequacy of primary and specialty networks and monitor the quality of care provided to Medicaid managed care beneficiaries.

Key Evaluation Questions

1. How has quality of care for Medicaid managed care organizations changed over the life of the Demonstration?
2. How does quality of care for New York Medicaid managed care enrollees compare with national benchmarks?
3. Has the gap in measures of quality of care and satisfaction narrowed between New York Medicaid managed care plans and commercial plans?
 - *Outcome measures and variables:*
 - (1) Changes in managed care quality measures for the MCOs that serve Medicaid managed care enrollees. Covered areas will include but not be limited to the following areas:
 - Provider Network
 - Child & Adolescent Health
 - Women's Health
 - Adults Living With Illness
 - Behavioral Health
 - Access and Service
 - (2) Changes in member satisfaction measures for the MCOs that serve Medicaid managed care enrollees.
 - (3) Comparison of New York Medicaid managed care quality and satisfaction results with national benchmarks.
 - (4) Narrowing of the gap in measures of quality and satisfaction between New York Medicaid managed care plans and commercial plans.
4. How have Medicaid financial mechanisms/ payment methods evolved to support program goals to achieve a higher quality health care system?
 - *Outcome measures and variables:* Qualitative descriptions of new financial mechanisms to support Demonstration goals, such as pay-for-performance initiatives, quality incentives, move to risk-adjusted capitation rates, and early experience with their use.
5. Has the HIV Special Needs Plan (SNP) been a successful model for delivery of care to persons living with HIV/ AIDS and their eligible dependents?

- *Outcome measures and variables:* Qualitative descriptions of successes in and barriers to enrollment growth in disease specific model, comparison of quality outcomes to other delivery models that serve the population and assessment of the programmatic and financial viability of HIV SNPs.

Data Sources

- MMIS
 - DOH Administrative Data
 - Quality Assurance Reporting Requirements (QARR)
 - Consumer Assessment of Health Plans Survey (CAHPS)
6. Has the Medicaid Advantage Program been successful in integrating Medicare and Medicaid covered services for dually eligible beneficiaries?
- a. *Outcome measures and variables:* Quantitative and qualitative descriptions of MCO and recipient interest in integrated programs, analysis of the quality of care delivered through integrated model, member satisfaction with integrated programs and an assessment of the feasibility of replicating integrated models using Medicare Advantage.

Data Sources

- MMIS
 - DOH Administrative Data
 - Quality Assurance Reporting Requirements (QARR)
 - Consumer Assessment of Health Plans Survey (CAHPS)
- DOH Administrative Data
 - National HEDIS data

GOAL 4: EXPANDING HEALTH CARE COVERAGE

Goal

Goal 4 of the Demonstration is to reduce the number of uninsured New Yorkers.

Activities

To achieve Goal 4, the Demonstration will expand coverage in the Family Health Plus program for low-income uninsured adults and implement a premium assistance program for individuals eligible for Family Health Plus who have access to cost-effective employer sponsored health insurance(ESHI) .

Key Evaluation Questions

1. How has expanded eligibility in the Family Health Plus program affected health coverage for low-income uninsured adults?
 - *Outcome measures and variables:* Number of beneficiaries enrolled in FHP, by beneficiary type, age category, and county.
2. How many individuals have enrolled in ESHI through the Family Health Plus Premium Assistance Program?
 - *Outcome measures and variables:* Number of beneficiaries enrolled in ESHI through FHPlus by beneficiary type, age category, and county.

Data Sources

- MMIS
- Current Population Survey (CPS) data on insurance coverage trends

FAMILY PLANNING EXPANSION PROGRAM: EVALUATION GOALS, ACTIVITIES, MEASURES, AND DATA

This section describes the evaluation plan's goals, activities, evaluation questions, measures/variables, and data sources related to the Family Planning Expansion Program.² As noted above, in practice the Family Planning Expansion evaluation will be conducted independently from the larger Partnership Plan evaluation. However, the results will be integrated into the Partnership Plan evaluation's final report.

Goal

The goal of the Family Planning Expansion Demonstration is to avert unintended pregnancies by increasing access to publicly funded family planning services.

Activities

To achieve Goal 1, the Demonstration will expand eligibility for family planning services, including but not limited to services related to contraception or sterilization.

Key Evaluation Questions

1. How many individuals received Medicaid family planning services as a result of the Family Planning Expansion Demonstration?
 - *Outcome measures and variables:* Number and percentage change of individuals receiving Medicaid family planning services as a result of the Demonstration; type of services received.
2. How many births occur to participants covered by the Demonstration?
 - *Outcome measures and variables:* Number of actual births that occur to Demonstration participants.
3. To what extent did Family Planning Expansion Program participants receive a clinical referral for primary care?
 - *Outcome measures and variables:* Number of Family Planning Expansion Program participants receiving a clinical referral.
4. To what extent have pregnancies been averted as a result of the Demonstration?
 - *Outcome measures and variables:* "Averted births" = (base-year fertility rate) - (fertility rate of Demonstration participants during Demonstration Year) * (number of Demonstration participants during Demonstration Year). See further discussion in data section below.
5. What expenditures are associated with Medicaid-funded births?
 - *Outcome measures and variables:* Average total Medicaid expenditures for a Medicaid-funded birth each year (including prenatal services and delivery and pregnancy-related services and services to infants from birth through age 1).
6. To what extent have averted births resulting from the Demonstration yielded cost savings?

² Family Planning Expansion Program participants will include all individuals who obtain one or more covered medical family planning services through the Demonstration.

- *Outcome measures and variables:* “Averted births” multiplied by average expenditures for a Medicaid-funded birth each year.
7. Are eligibility re-determinations conducted on an annual basis?
- *Outcome measures and variables:* Number of annual re-determinations conducted compared to number of determinations due.

Data Sources

- MMIS
- DOH Administrative Data
- Vital Records

As specified in the Special Terms and Conditions pertaining to the Demonstration, the State will submit to CMS base-year fertility rates and a methodology and data sources for calculating the fertility rates no later than March 1, 2007.

These rates will:

- Reflect fertility rates during Base Year 2000 for women, age 19-44 years, with family incomes at or below 200 percent FPL and ineligible for Medicaid except for pregnancy
- Be adjusted for age for all potential Demonstration participants
- Include births paid for by Medicaid

At the end of each Demonstration year (DY), a DY fertility rate will be determined by summing the age-specific rates using the age distribution of the Demonstration participants during that DY to weight the age-specific fertility rates, unless the State demonstrates that the age distribution is consistent with the prior DY(s). The annual age distribution categories will correspond with the base-year age-specific fertility rates. The base-year fertility rate and the DY fertility rate will be used to calculate a measure of births averted through the Demonstration using the following formula: Births Averted = (base-year fertility rate) - (fertility rate of Demonstration participants during DY) X (number of Demonstration participants during DY).

Table 1: Evaluating the Partnership Plan Demonstration

Goal 1 Expanded Managed Care Enrollment			
PRE	Establish baseline measurements in variables described below		
1	How many Medicaid beneficiaries were enrolled in Medicaid managed care as a result of the Demonstration?	Number of beneficiaries enrolled in managed care organizations, by beneficiary type, age category, and county.	MMIS
Goal 2 Improving Health Care Access			
PRE	Establish baseline measurements in variables described below		
1	To what extent has the Demonstration improved access to primary care services?	Physician participation in Medicaid managed care plans, by specialty and county; number of primary care visits PMPM; appropriate HEDIS/QARR access measures; appropriate CAHPS measures.	MMIS; DOH Administrative Data; HEDIS/QARR; CAHPS
2	To what extent has the Demonstration improved access to specialty care services?	Physician participation in Medicaid Managed care plans by specialty and county; appropriate CAHPS measures.	MMIS; DOH Administrative Data; CAHPS
Goal 3 Improved Quality of Care			
PRE	Establish baseline measurements in variables described below		
1	How has quality of care for Medicaid managed care organizations changed over the life of the Demonstration?	<p>(1) Changes in managed care quality measures for the health plans that serve Medicaid managed care enrollees. Covered areas will include but not be limited to the following areas:</p> <ul style="list-style-type: none"> • Provider Network • Child & Adolescent Health • Women's Health • Adults Living With Illness • Behavioral Health • Access and Service. <p>(2) Changes in member satisfaction measures for the health plans that serve Medicaid managed care enrollees.</p> <p>(3) Comparison of New York Medicaid managed care measures of quality and satisfaction with national benchmarks.</p>	<p>(1) QARR</p> <p>(2) CAHPS</p> <p>(3) National HEDIS data; QARR; CAHPS</p>

2	How does quality of care for New York Medicaid managed care enrollees compare with national benchmarks?		
3	Has the gap in measures of quality and satisfaction narrowed between New York Medicaid managed care plans and commercial plans?	Narrowing of the gap in measures of quality and satisfaction between New York Medicaid managed care plans and commercial plans.	QARR; CAHPS
4	How have Medicaid financial mechanisms/payment methods evolved to support program objectives to advance a higher quality health care system?	Qualitative descriptions of new financial mechanisms to support Demonstration goals, such as pay-for-performance initiatives, quality incentives, move to risk-adjusted capitation rates, etc. and early experience with their use.	Internal DOH documents and reports
5.	Has the HIV Special Needs Plan been a successful model for delivery of care to persons with living with HIV/AIDS and their eligible dependents?	(1) Number of beneficiaries enrolled in HIV SNPs by beneficiary type, age category, and county. (2) Description of factors that influence ability to increase enrollment. (3) HIV Special Needs Plan quality measures compared to mainstream Medicaid managed care plans and Medicaid FFS. (4) Programmatic, operational and financial viability of the continuation of the HIV SNP model.	MMIS; DOH Administrative Data QARR; MMIS data; administrative data DOH Internal Data
6.	Has the Medicaid Advantage Program been successful in integrating Medicare and Medicaid covered services for dually eligible beneficiaries?	(1)Number of MCOs and beneficiaries participating in integrated programs. (2)Quality measures for enrollees of integrated plans.	MMIS QARR QARR; Medicare quality

		(3) Member satisfaction with integrated models	measured
		(4) Cost efficiencies realized by Medicaid program as a result of integration of Medicare and Medicaid.	CAHPs DOH administrative data; MMIS
		(5) Ability to replicate integrated programs statewide.	DOH Internal Data
Goal 4	Expanded Health Care Coverage		
1	How has expanded eligibility in the Family Health Plus program (FHP) affected health coverage for low-income uninsured adults?	Number of beneficiaries enrolled in FHP, by beneficiary type, age category, and county.	MMIS; Current Population Survey data
2.	How many individuals have enrolled in ESHI through the FHPlus Premium Assistance Program ?	Number of beneficiaries enrolled in ESHI through FHPlus by beneficiary type, age category, and county.	MMIS;

Table 2: Evaluating the Family Planning Expansion Demonstration

	Research Questions	Outcome Measures and Variables	Data Sources
PRE	Establish baseline measurements in variables described below		
1	How many individuals received Medicaid family planning services as a result of the Family Planning Expansion Program Demonstration?	Number and percentage change of individuals receiving Medicaid family planning services as a result of the Demonstration ; types of services received.	MMIS
2	How many births occur to participants covered by the Demonstration?	Number of actual births that occur to Demonstration participants.	MMIS Vital Records
3	To what extent did family planning beneficiaries receive a clinical referral for primary care?	Number of Family Planning Expansion Program participants receiving a clinical referral.	DOH Administrative Data
4	To what extent have pregnancies been averted as a result of the Demonstration?	“Averted births” = (base-year fertility rate) – (fertility rate of Demonstration participants during Demonstration Year) (number of Demonstration participants during Demonstration Year).	DOH Administrative Data
5	What expenditures are associated with Medicaid-funded births?	Average total Medicaid expenditures for a Medicaid-funded birth each year (including prenatal services and delivery and pregnancy-related services and services to infants from birth through age 1).	MMIS
6	To what extent have averted births resulting from the Demonstration yielded cost savings?	“Averted births” multiplied by average expenditures for a Medicaid-funded birth each year.	DOH Administrative Data; MMIS
7	Are eligibility re-determinations conducted on an annual basis?	Number of annual re-determinations conducted compared to number of determinations due.	DOH Administrative Data

**ATTACHMENT XIV
SPECIAL TERMS AND CONDITIONS
F-SHRP**

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00234/2

TITLE: Federal-State Health Reform Partnership Medicaid Section 1115 Demonstration

AWARDEE: New York Department of Health

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New York's Federal-State Health Reform Partnership section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the New York Department of Health (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective October 1, 2006 unless otherwise specified. This Demonstration is approved through September 30, 2011.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility, Benefits, and Enrollment; Delivery Systems; Federal-State Health Reform Partnership Activities; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Medicaid Program Savings Measures; Evaluation of the Demonstration; and Schedule of State Deliverables for the Demonstration.

Additionally, one attachment has been included to provide supplementary information and guidance for STC 42.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The aging of New York's population, the continued shift in care from institutional to outpatient settings and the quality and efficiency advantages that are available through health information technology present the State with significant reform opportunities. The State has asked the Federal government to partner with it to implement reform initiatives that will improve quality of care and result in long-term savings for both the State and Federal government. The reform initiatives that the State will pursue under this Demonstration include:

1. **Rightsizing Acute Care Infrastructure.** New York's acute care infrastructure is outdated and oversized, while the facilities are highly leveraged with debt. The inexorable migration of health care services to the outpatient setting has added to the significant excess capacity that exists in the State, estimated at over 19,000 beds. As a result, State law was enacted establishing the Commission on Health Care Facilities in the 21st Century (Commission) which is charged with recommending reconfiguration measures, including downsizing, restructuring and/or facility closures. Such measures will reduce future Medicaid inpatient hospital costs.
2. **Reforming Long Term Care.** The growth of non-institutional alternatives for long-term care services such as assisted living, advances in medical technology, overall improvement in the health of potential consumers and caregivers, and increasing preference for less restrictive alternatives is generating less demand for nursing facility services. New York will pursue the rightsizing of its long-term care system; implementation of a locally based but statewide point of entry (POE) system to help ensure appropriate services are rendered to recipients; a home modification program to enable recipients to stay at home; and a telehome care program to help individuals stay healthy and at home.

3. **Improvement in Primary/Ambulatory Care.** As increased emphasis is placed on services rendered in outpatient settings, capacity and quality become of primary importance. Under this Demonstration, New York will address the shortage of primary care services; implement programs to better manage individuals with chronic conditions, and collect quality of care data on outpatient services.

CMS will monitor these activities to ensure that the Demonstration delivers on the promise of increased efficiency and savings that it has been given.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these STCs are part, shall apply to the Demonstration.
3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in the applicable law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy that occur after the approval date of this Demonstration, unless the provision being changed is explicitly waived under the STCs herein governing the Demonstration. This requirement shall also apply to all applicable regulation and policy issued by CMS with respect to the Deficit Reduction Act of 2005, signed into law on February 8, 2006, including but not limited to the documentation of citizenship requirements contained in section 1903(x) of the Social Security Act (the Act).
4. **Impact on Demonstration of Changes in Federal Law.** To the extent that a change in Federal law requires either a reduction or an increase in Federal financial participation (FFP) in expenditures under such the Demonstration, the State will adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified budget neutrality agreement would be effective upon the implementation of the change. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The State shall not be required to submit title XIX State plan amendments for changes to any populations covered solely through the Demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to the health care reforms undertaken by this Demonstration, designated state health programs, eligibility, enrollment, benefits, enrollee rights, delivery systems, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.
7. **Amendment Process:** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:

- a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;
- b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis shall include current “with waiver” and “without waiver” status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;
- c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
- d) If applicable, a description of how the evaluation design shall be modified to incorporate the amendment provisions.

8. Continuation of the Demonstration. This Demonstration will expire on September 30, 2011 and may not be extended. The State will comply with the Demonstration phase-out requirements and the transfer of populations as outlined in paragraph 9 below.

9. Demonstration Phase-Out. The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

If the State wants to continue limiting freedom of choice of providers for the Demonstration populations specified in Section VI, paragraph 45, the authority to do so must be transferred by amendment to the Partnership Plan demonstration project (11-W-00114/2) if that demonstration is still in operation. Otherwise, the State must request new authority to limit freedom of choice of providers for these populations.

10. CMS Right to Terminate or Suspend. CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. Finding of Non-Compliance. The State does not relinquish its rights to challenge CMS’ finding that the State materially failed to comply.

12. Withdrawal of Waiver Authority. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

13. Adequacy of Infrastructure. The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; implementation of milestones; and reporting on financial and other Demonstration components.

14. **Quality Review of Eligibility.** The State will continue to submit by December 31st of each year an alternate plan for Medicaid Eligibility Quality Control (MEQC) as permitted by Federal regulations at 42 CFR 431.812(c).
15. **Public Notice and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 FR 49249 (September 27, 1994) when any program changes to the Demonstration, including but not limited to those referenced in paragraph 6 are proposed by the State.
16. **Compliance with Managed Care Regulations.** The State must comply with the managed care regulations at 42 CFR 438 et. seq., except as expressly waived or referenced in the expenditure authorities incorporated into the STCs. Capitation rates must be developed and certified as actuarially sound in accordance with 42 CFR 438.6.
17. **Federal Funds Participation.** No Federal matching funds for expenditures for this Demonstration will be provided until the effective date identified in the Demonstration approval letter. No FFP is available for this Demonstration for Medicare Part D drugs.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

The mandatory managed care program operated by New York provides Medicaid State Plan benefits through comprehensive managed care organizations to those recipients eligible under the State plan as noted below.

18. Eligibility.

The eligibility categories described below are subject to all applicable Medicaid laws and regulations, except as expressly waived through the waiver authorities for this Demonstration.

State Plan Mandatory and Optional Groups	FPL Level and/or other qualifying criteria
Children under age 1	Up to 200 % FPL
Children 1 through 5	Up to 133% FPL
Children 6 through 18	Up to 100% FPL
Children 19-20	Monthly income standard (determined annually)
Adult (21-64) AFDC-related family members	Monthly income standard (determined annually)

Under the Partnership Plan Demonstration (11-W-00114/2), the recipients in the categories above who live in New York City and 23 other counties are mandated into managed care enrollment. Under this Demonstration, recipients in these categories who live in the following counties will now be mandated into managed care enrollment:

Allegany	Cortland	Dutchess	Fulton	Montgomery
Putnam	Orange	Otsego	Schenectady	Seneca
Sullivan	Ulster	Washington	Yates	

State Plan Mandatory and Optional Groups	FPL Level and/or other qualifying criteria
Adults and children (0-64) receiving Supplemental Security Income (SSI) payments or otherwise disabled	Monthly income standard (determined annually)
Adults (65+)	Monthly income standard (determined annually)

Under the Partnership Plan Demonstration (11-W-00114/2), the recipients in the categories above are not mandated into managed care enrollment. Under this Demonstration, all recipients in these categories who live in New York City and the counties that participate in the Partnership Plan will now be mandated into managed care enrollment.

19. **Eligibility Exclusions.** Notwithstanding the eligibility criteria in paragraph 18, the following persons are excluded from the Medicaid mandatory managed care program.

Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities or residents of state certified or voluntary treatment facilities for children and youth
Patients in residential health care facilities (RHCF) at time of enrollment and residents in a RHCF who are classified as permanent
Participants in capitated long term care demonstration projects
Medicaid-eligible infants living with incarcerated mothers
Infants weighing less than 1200 grams at birth and other infants less than 6 months who meet the criteria for SSI-related categories
Individuals with access to comprehensive private health insurance if cost effective
Foster care children in the placement of a voluntary agency
Foster care children in direct care [at the option of the local Department of Social Services (LDSS)]
Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid eligible for less than six months (except for pregnant women)
Individuals receiving long-term care services through long-term home health care programs, or child care facilities (except ICF services for the developmentally disabled)
Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
Individuals placed in Office of Mental Health (OMH)-licensed family care homes
Individuals enrolled in the restricted recipient program
Individuals with a "county of fiscal responsibility" code 99 in MMIS
Individuals receiving hospice services (at time of enrollment)
Youth in the care and custody of the commissioner of the Office of Family & Children Services
Individuals with a "county of fiscal responsibility" code of 97 (OMH in MMIS)
Individuals with a "county of fiscal responsibility" code of 98 (until program features are approved by the state and operational at the local district level to permit these individuals to voluntarily enroll in Medicaid managed care)
Individuals under sixty-five years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast and/or cervical cancer early detection program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable health coverage.
Individuals who are eligible for Medicaid buy-in for the working disabled and must pay a premium

20. **Eligibility Exemptions.** Notwithstanding the eligibility criteria in paragraph 18, the following persons may not be required but may voluntarily enroll in the Medicaid managed care program.

Individuals who are HIV+
Individuals with severe and persistent mental illness and children with serious emotional disturbances except those individuals whose behavioral health benefits are provided through the Medicaid fee-for-service program.
Individuals eligible for both Medicare/Medicaid (dual-eligibles) *
Individuals for whom a managed care provider is not geographically accessible
Individuals with chronic medical conditions who have been under active treatment for at least six months with a sub-specialist who is not a network provider for any Medicaid MCO in the service area or whose request has been approved by the New York State Department of Health Medical Director because of unusually severe

chronic care needs
Individuals with end stage renal disease (ESRD)
Residents of intermediate care facilities for the mentally retarded (ICF/MR)
Individuals with characteristics and needs similar to those residing in an ICF/MR
Individuals already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO in the service area
Individuals with a developmental or physical disability receiving services through a Medicaid home and community based services (HCBS) waiver
Individuals with a developmental or physical disability whose needs are similar to participants receiving services through a Medicaid (HCBS) waiver
Participants in the Medicaid model waiver (care-at-home) programs
Individuals whose needs are similar to participants receiving services through the Medicaid model waiver (care-at-home) programs
Residents of alcohol/substance abuse long term residential treatment programs
Homeless individuals in the shelter system (at the option of the LDSS). Note: in New York City, all homeless individuals are exempt.
Native Americans
Individuals who cannot be served by a managed care provider due to a language barrier
Individuals temporarily residing out of district
Individuals with a “county of fiscal responsibility code of 98” (OMRDD in MMIS) in counties where program features are approved by the State and operational at the local district level to permit these individuals to voluntarily enroll.
Individuals who are eligible for the Medicaid buy-in for the working disabled and are not required to pay a premium

* These persons may **only** join a qualified Medicaid Advantage Plan

21. Mandatory Managed Care Program Benefits. Benefits provided through this Demonstration for the Medicaid managed care program are as follows:

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21 only)
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services
Dental services
Physical and occupational therapy
Speech, hearing and language therapy
Prescription drugs, over-the-counter drugs and medical supplies
Durable medical equipment including prosthetic and orthotic devices, hearing aids and prescription shoes
Vision care services including eyeglasses
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
Nursing facility services
Personal care services

Case management services
Hospice care services
TB-related services
Inpatient and outpatient behavioral health services (mental health and chemical dependence services)
Emergency medical services including emergency transportation
Adult day care
Personal Emergency Response Services (PERS)
Renal dialysis
Home and Community Based Services waivers (HCBS)
Care at Home Program (OMRDD)
Non-emergency transportation
Experimental or investigational treatment (covered on a case by case basis)

22. Facilitated Enrollment. MCO, health care provider and community-based organization facilitated enrollers will engage in those activities described in 42 CFR 435.904(d)(2), as permitted by 42 CFR 435.904(e)(3)(ii), within the following parameters:

- a) Facilitated enrollers will provide program information to applicants and interested individuals as described in 42 CFR 435.905 (a).
- b) Facilitated enrollers must afford any interested individual the opportunity to apply for Medicaid without delay as required by 42 CFR 435.906.
- c) If an interested individual applies for Medicaid by completing the information required under 42 CFR 435.907(a) and (b) and 42 CFR 435.910(a) and signing a Medicaid application, that application must be transmitted to the local department of social services (LDSS) for determination of eligibility.
- d) The protocols for facilitated enrollment practices between the LDSS and the facilitated enrollers must:
 - i. Ensure that choice counseling activities are closely monitored to minimize adverse risk selection; and
 - ii. Specify that determinations of Medicaid eligibility are made solely by the LDSS.
- e) The State must submit all protocols and training materials for any counties beginning to use facilitated enrollment processes to CMS for review and approval at least thirty days prior to starting facilitated enrollment.

V. DELIVERY SYSTEMS

23. Contracts. Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers (FQHC) shall continue in force.

Payments under contracts with public agencies, that are not competitively bid in a process involving

multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

24. Institutions for Mental Diseases (IMDs). Services to enrollees of the State's mandatory managed care program who are patients in IMDs will be covered only to the extent permitted under Section VIII, paragraph 51.

25. Health Services to Native American Populations. The plan for patient management and coordination of services for Medicaid-eligible Native Americans developed for the Partnership Plan in consultation with the Indian tribes and/or representatives from the Indian health programs located in participating counties shall apply to recipients in this Demonstration.

VI. FEDERAL-STATE HEALTH REFORM PARTNERSHIP (F-SHRP) ACTIVITIES

Funding

26. **State Obligation.** The State must invest \$3.0 billion over the five-year demonstration period for health care reform initiatives in order to receive \$1.5 billion in FFP.
- a. These initiatives will include programs that will promote the efficient operation of the State's health care system; consolidate and right-size New York's health care system by reducing excess capacity in the acute care system; shift emphasis in long-term care from institutional-based to community-based settings; expand the use of e-prescribing, electronic medical records and regional health information organizations; and improve ambulatory and primary care provision.
 - b. These reform initiatives may include but are not limited to:
 - i. Reform activities set forth in (a) above and consistent with the goals of Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY)
 - ii. State Department of Health programs—
 - 1. Diagnostic and Treatment Centers for Indigent Care
 - iii. State Office on Aging programs – Expanded In-Home Services to the Elderly
 - iv. Office of Mental Health programs –
 - 1. Community Support Services and Residential Services Program
 - 2. New York University Child Studies Center
 - v. Office of Alcoholism and Substance Abuse Services – Prevention and Treatment Program
 - c. Additional State-only health care reform investments or changes in the listed uses will be considered an amendment to the Demonstration and processed in accordance with Section III, paragraph 7.
27. **Federal Financial Participation for Designated State Health Programs (DSHP).**
- a) **Five-year Demonstration Period.** Federal Financial Participation (FFP) will be available beginning October 1, 2006, for State expenditures on the DSHP described in paragraph 28 incurred by the State during the period October 1, 2006 and ending September 30, 2011 subject to the limitations outlined below.

- i. FFP Cap. FFP for DSHP is limited to the lesser of \$1.5 billion or half the amount of monies the State expends over the demonstration period on the health care reform activities described in paragraph 26.
- ii. Milestones. FFP will only be available if the milestones outlined in paragraphs 31 through 37 are completed in accordance with the due dates set forth for each milestone.
- iii. Demonstrated Savings. The State must achieve an amount of total Medicaid program savings by the end of the Demonstration period as calculated under the provisions of Section X.
- iv. Reconciliation and Recoupment. If the Federal share of these savings are not at least equal to the amount determined under subparagraph (i) the State must return to CMS the amount of Federal funds that exceed Medicaid program savings achieved.
 - 1. As part of the annual report required under Section IV, paragraph 43, the State will report both DSHP claims and expenditures for health care reforms.
 - 2. The reported claims and expenditures will be reconciled at the end of the Demonstration with the State's MBES submissions.
 - 3. Any repayment required under this subparagraph will be accomplished by the State making an adjustment for its excessive claim for FFP on the CMS-64 by entering an amount in line 10(b) of the Summary sheet equal to the amount by which FFP exceeds Medicaid program savings.

b) Annual Demonstration Year. The following limitations apply to Federal funding of DSHP in each Demonstration year:

- i. FFP Cap. FFP for DSHP is limited to the lesser of \$300 million or half of the State's expenditures on the health care reform activities specified in paragraph 26. Any remaining FFP authority, if any, between the \$300 million limit and the State's expenditures on health care reform, may not roll over into subsequent demonstration years.
- ii. Milestones. FFP will only be available if the milestones outlined in paragraphs 31 through 37 are completed in accordance with the due dates set forth for each milestone.
- iii. Timing. The State may not draw Federal funds for the programs described in paragraph 28 until such time as the State makes expenditures for the health care reform initiatives described in paragraph 26.
- iv. Reconciliation and Recoupment.
 - 1. As part of the quarterly report required under Section IV, paragraph 42, the State will report both DSHP claims and expenditures for health care reforms.
 - 2. The reported claims and expenditures will be reconciled quarterly with the State's MBES submission.
 - 3. Any amount of FFP provided in excess of the calculation in subparagraph 2 (iii) will be reduced from future grant awards. To accomplish this, the State must make an adjustment for its excessive claim for FFP on the CMS-64 by entering an amount in line 10(b) of the Summary sheet equal to the excessive claims.

- c) **FFP Expiration.** The State agrees that the authority for Federal funding of DSHP expires on September 30, 2011; will not be available for any expenditure incurred after September 30, 2011; and may not be extended.

28. Designated State Health Programs. Subject to the conditions outlined in paragraphs 27 and 30 (f), FFP may be claimed for expenditures made for the following designated State health programs beginning October 1, 2006 through September 30, 2011:

- a) Health Care Reform Act programs –
 - i. Healthy New York
 - ii. AIDS Drug Assistance
 - iii. Tobacco Use Prevention and Control
 - iv. Health Workforce Retraining
 - v. Recruitment and Retention of Health Care Workers
 - vi. Telemedicine Demonstration
 - vii. Pay for Performance Initiatives
- b) State Office on Aging programs –
 - i. Community Services for the Elderly
 - ii. Expanded In-Home Services to the Elderly
- c) Office of Mental Health – Community Support Services and Residential Services Program
- d) Office of Mental Retardation/Developmental Disabilities – Residential and Community Support Services
- e) Office of Alcoholism and Substance Abuse Services – Prevention and Treatment Program
- f) Office of Children and Family Services - Committees on Special Education direct care programs
- g) State Department of Health – Early Intervention Program Services

29. Designated State Health Programs Claiming Process

- a) Documentation of each designated state health program's expenditures must be clearly outlined in the State's supporting work papers and be made available to CMS.
- b) Federal funds must be claimed within two years after the calendar quarter in which the State disburses expenditures for the designated state health programs in paragraph 28. Claims may not be submitted for State expenditures disbursed after September 30, 2011. The State may draw Federal funds only as the State makes disbursements for the health care reform initiatives identified in paragraph 26.
- c) Sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that Federal funds from any Federal programs are received for the designated state health programs listed in paragraph 28, they shall not be used as a source of non-Federal share.
- d) The administrative costs associated with programs in paragraph 28 and any others subsequently added by

amendment to the Demonstration shall not be included in any way as Demonstration and/or other Medicaid expenditures.

- e) Any changes to the designated state health programs listed in paragraph 28 shall be considered an amendment to the Demonstration and processed in accordance with Section III, paragraph 7.

Milestones

The State will be required to complete various activities by the prescribed dates below in order to continue the Demonstration. If the State fails to meet any milestone, with the exception of paragraph 30, it must begin Demonstration close-out procedures in accordance with Section III, paragraph 9. These milestones include State-level Medicaid reforms, reporting requirements related to F-SHRP, and compliance with Administration policy.

30. Fraud and Abuse Recoveries. Medicaid expenditure data for FFY 2005 shows that the State recovers less than one percent of its total Medicaid expenditures. By the end of this Demonstration, the State will be responsible for increasing its Medicaid fraud and abuse recoveries to at least 1.5 percent of its total Medicaid expenditures for FFY 2005 (\$42.9 billion). This will be monitored using State-reported fraud and abuse recoveries on the CMS-64, line 9c for each Federal fiscal year.

- a) By October 31, 2006, the State must develop and submit to CMS its plan for achieving this milestone by the end of the demonstration period, including details of Office of Medicaid Inspector General (OMIG) staffing and new budget proposals to further enhance OMIG resources.
- b) By September 30, 2008, (for the period 10/1/07 through 9/30/08), the State must demonstrate that its annual level of fraud and abuse recoveries is equal to .5% of total computable Medicaid expenditures (\$215 million).
- c) By September 30, 2009, (for the period 10/1/08 through 9/30/09), the State must demonstrate that its annual level of fraud and abuse recoveries is equal to .75 percent of total computable Medicaid expenditures (\$322 million).
- d) By September 30, 2010, (for the period 10/1/09 through 9/30/10), the State must demonstrate that its annual level of fraud and abuse recoveries is equal to 1 percent of total computable Medicaid expenditures (\$429 million).
- e) By September 30, 2011, (for the period 10/1/10 through 9/30/11), the State must demonstrate that its annual level of fraud and abuse recoveries is equal to 1.5 percent of total computable Medicaid expenditures (\$644 million).
- f) Achievement of the above targets will be assessed within 90 days after the end of each Demonstration year. If the State does not meet the targets in any of the Demonstration years, the State will be required to pay the Federal government the lesser of:
 - i. the dollar difference between actual and target recoveries (as specified above); or
 - ii. total claimed FFP for designated state health programs in that Demonstration year, not to exceed \$500 million over the five-year Demonstration period.

The Federal government will recoup the penalty calculated in items (i) and (ii) above. To accomplish this, the State must make an adjustment for its claims for FFP on the CMS-64 by entering an amount in line 10(b) of the Summary sheet equal to the amount of the penalty divided by the federal matching rate. This will ensure that the State's claim of FFP is reduced by the total computable amount calculated in items (i) and (ii) above.

31. Preferred Drug List. States currently have flexibility to control rising drug costs by implementing a preferred drug list (PDL). By February 1, 2007, the State must implement a PDL for Medicaid mandatory, optional and expansion populations, with the exception of enrollees in Family Health Plus. This PDL must remain in effect for the duration of this Demonstration period. If the State ends its PDL prior to the end of the demonstration, the Federal government will immediately cease providing FFP for designated State health programs.

32. Baseline Data and Reporting. After collaboration between the State and Federal governments to define the base year, the State must report to CMS by November 30, 2006 baseline data including, but not limited to:

- a) Hospitals: total hospital discharges; Medicaid discharges, total hospital expenditures; and total hospital debt.
- b) Nursing homes: total nursing facility days; Medicaid days, total nursing facility expenditures; and total nursing facility debt.
- c) Managed care: total fee-for-service and managed care expenditures and enrollment for TANF and SSI enrollees, including the aged.

Once the baseline data is established, quarterly and annual reporting on these data elements is required under Section VII, paragraphs 42 and 43.

33. Employer Sponsored Insurance. States may design programs to incorporate private insurance options for beneficiaries. Under this milestone, the State will be required to increase health insurance coverage by coordinating currently available Medicaid funding with private insurance options.

- a) By January 1, 2008, the State must implement, subject to CMS approval, a program to increase the number of currently uninsured but employed New York residents with private insurance coverage. This private insurance coverage program should include members of New York's current waiver program, Family Health Plus.
- b) By January 1, 2009, the State must document increased rates of private insurance for individuals referenced above.

34. Programmatic Changes.

a). By October 31, 2006, the State must implement the following Medicaid cost containment initiatives enacted in New York's 2005/2006 State Budget relevant to Demonstration programs. If the State ends its cost containment initiatives prior to the end of the demonstration, the Federal government will cease providing FFP for designated State health programs.

- 1. Restructure the benefit package and cost sharing requirements for the Family

Health Plus program (authorized under the Partnership Plan Demonstration 11-W-00114/2)

2. Increase Medicaid co-payments for drugs from \$.50 to \$1 for generic drugs and from \$2 to \$3 for brand-name drugs;
 3. Implement managed care premium cost containment including a one year premium freeze and cap on administrative costs;
 4. Implement mandatory managed care enrollment for SSI recipients;
 5. Expand the managed long term care program; and
 6. Begin implementation of a collaborative multiple payer Pay for Performance demonstration.
- b. By February 1, 2007, the State must submit evidence that the State has implemented at least one new Medicaid cost efficiency initiative. These may include, but are not limited to State plan flexibility options offered by the Deficit Reduction Act of 2006. If the initiative requires legislative approval in order for the State to implement, legislative approval must be granted no later than July 1, 2007, and implementation must begin no later than January 1, 2008. After implementation, if the State ends its cost efficiency initiative prior to the end of the demonstration, the Federal government will cease providing FFP for designated state health programs.

No initiative implemented as a result of other milestones or savings measures may be used to comply with this requirement.

35. **Improvement in ADA Compliance.** By March 31, 2007, the State must submit a report outlining the State's plan for updating its on-site reviews of ADA compliance, including sampling methodology and timeframes. The report shall include an evaluation of possible incentives for MCOs to improve accessibility at beneficiary point-of-service.
36. **Single Point-of-Entry.** By April 1, 2008, the State must have implemented, subject to CMS approval, a program to create a single-point-of-entry for Medicaid recipients needing long-term care in at least one region of the State.
37. **Report on Progress of the Commission.** The State must submit two reports on the work of the Commission:
- a) By January 31, 2007, a report which shall include: certification from the State that there are no State statutory impediments to implementation of the Commission's recommendations on reconfiguring the State's general hospital and nursing home bed capacity; steps taken to implement those recommendations on or after January 1, 2007; and a timeline for implementation of those recommendations.
 - b) By July 15, 2008, a report on the final recommendations of the Commission. This report shall provide a certification that each of the Commission's recommendations has been acted upon, as well as the strategy and timeline for full implementation. Any recommendations that have been completely implemented by this date should be so noted. The report shall also address how the implementation of the Commission's recommendations will impact the provision of primary/ambulatory care services in affected communities.

VII. GENERAL REPORTING REQUIREMENTS

38. **General Financial Requirements.** The State must comply with all general financial requirements set forth in section VIII.
39. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR 438 et. seq. except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.
40. **Reporting Requirements Related to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in section IX and the Medicaid Program Savings set forth in section X.
41. **Monthly Calls.** Monthly discussions between CMS and the State regarding this demonstration shall be conducted as part of the monthly calls held for the Partnership Plan Demonstration (11-W-00114/2). During these calls, the progress of the health care reforms authorized by this Demonstration shall be discussed, as well as any pertinent State legislative developments, and any Demonstration amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.
42. **Quarterly Reports:** The State must submit progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter.
43. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, health reform initiatives, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. Additionally, the annual report should include updated workbooks for both the reform metrics and budget neutrality monitoring. The State must submit the draft annual report no later than January 1 after the close of each Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

VIII. GENERAL FINANCIAL REQUIREMENTS

44. **Quarterly Reports.** The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section IX.
45. **Reporting Expenditures Under the Demonstration:** The following describes the reporting of expenditures under the Demonstration:
 - a) In order to track expenditures under this Demonstration, the State must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All Demonstration expenditures must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made).

- b) For monitoring purposes, quarterly cost settlements and pharmaceutical rebates relevant to the Demonstration will be allocated (using an approved methodology) to the Demonstration populations specified in subparagraph (i) and offset against current quarter waiver expenditures. Demonstration expenditures net of these cost settlement offsets will be reported on Form CMS 64.9 Waiver. Amounts offset will be identifiable in the State's supporting work papers and made available to CMS.
- c) For each Demonstration year, seven (7) separate waiver Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below, to report expenditures for the following Demonstration populations, as well as for the designated State health programs.
- i. **Demonstration Population 1:** TANF Child under 1 through 20 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates counties [TANF Child New MC].
 - ii. **Demonstration Population 2:** TANF Adults aged 21-64 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties [TANF Adult New MC].
 - iii. **Demonstration Population 3:** Disabled Adults and Children 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006 [SSI 0-64 Current MC].
 - iv. **Demonstration Population 4:** Disabled Adults and Children 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 [SSI 0-64 New MC].
 - v. **Demonstration Population 5:** Aged or Disabled Elderly voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006 [SSI 65+ Current MC].
 - vi. **Demonstration Population 6:** Aged or Disabled Elderly required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 [SSI 65+ New MC].
 - vii. **Demonstration Expenditures:** Designated State Health Programs [DSHP]

46. **Expenditures Subject to the Budget Neutrality Cap.** For purposes of this section, the term “expenditures subject to the budget neutrality cap” must include all Medicaid expenditures on behalf of individuals who are enrolled in this Demonstration and for designated State health program expenditures as described in paragraph 45 (e) (i-vii). All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

All expenditures for managed care enrollment for Demonstration Populations 1 and 2 residing in the counties other than those specified in Section IV, paragraph 18 who are required to enroll in managed care

(“current” mandatory managed care enrollment) will be reported under the Partnership Plan Demonstration (11-W-00114/2). These expenditures may not be reported under this Demonstration.

47. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration, subject to the restriction in Section VI, paragraph 29 (d). All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
48. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
49. **Reporting Member Months.** The following describes the reporting of member months for Demonstration populations:
- a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 42, the actual number of eligible member months for the Demonstration Populations defined in paragraph 45 (e) (i-vi). The State must submit a statement accompanying the quarterly report which certifies the accuracy of this information.

The actual number of member months for current mandatory managed care enrollment for Demonstration Populations 1 and 2 as defined in paragraph 46 will not be used for the purpose of calculating the budget neutrality expenditure agreement for this Demonstration. They will be used for the budget neutrality expenditure agreement for the Partnership Plan Demonstration (11-W-00114/2).

To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively for up to two years as needed.
 - b) The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.
 - c) For the purposes of this Demonstration, the term “Demonstration eligibles” excludes unqualified aliens and refers only to the Demonstration Populations described in paragraph 45 (e) (i-vi).
50. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

51. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in section IX:

- a) Administrative costs, including those associated with the administration of the Demonstration, subject to the restriction in Section VI, paragraph 29 (d);
- b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan.
- c) FFP will be phased down for expenditures for services to a Partnership Plan enrollee age 21 through 64 residing in an Institution for Mental Disease for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days. The FFP match rate will be phased down as follows:

Demonstration Year	Demonstration Period	Allowable Portion of Expenditures
1	October 1, 2006 – September 30, 2007	100%
2	October 1, 2007 – September 30, 2008	50%
3	October 1, 2008 – September 30, 2009	0%

For Demonstration years 4 and 5, no FFP will be available for these services.

52. **Medicare Part D Drugs.** No FFP is available for this Demonstration for Medicare Part D drugs.

53. **Sources of Non-Federal Share.** The State certifies that the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds shall not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

- a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

54. **State Certification of Funding Conditions.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

- a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.
- b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost

documentation to support the State's claim for Federal match.

- d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

55. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

IX. MONITORING BUDGET NEUTRALITY

56. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the State to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

57. **Risk.** The State shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles under this budget neutrality agreement, but not for the number of Demonstration eligibles in each of the groups. By providing FFP for all Demonstration eligibles, The State shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing The State at risk for the per capita costs for Demonstration eligibles under this agreement, CMS assures that Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

58. **Demonstration Populations Used to Calculate the Budget Neutrality Cap.** The following Demonstration populations are used to calculate the budget neutrality cap and are incorporated into the following eligibility groups (EGs):

- a) **Eligibility Group 1:** TANF Child under 1 through 20 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates counties (Demonstration Population 1)
- b) **Eligibility Group 2:** TANF Adults aged 21-64 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties (Demonstration Population 2)
- c) **Eligibility Group 3:** Disabled Adults and Children 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 3)
- d) **Eligibility Group 4:** Disabled Adults and Children 0-64 required to enroll in managed care

in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 4)

- e) **Eligibility Group 5:** Aged or Disabled Elderly 65+ voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 5)
- f) **Eligibility Group 6:** Aged or Disabled Elderly 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 6)

59. **Budget Neutrality Expenditure Cap:** The following describes the method for calculating the budget neutrality expenditure cap for the Demonstration:

- a) For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each EG described in paragraph 58 as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under paragraph 49 for each EG, times the appropriate estimated per member per month (PM/PM) costs from the table in subparagraph (ii) below.
 - ii. The PM/PM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility groups subject to the budget neutrality agreement under this Demonstration are specified below.

Eligibility Group	Trend Rate	DY 1 (10/1/06 – 9/30/07)	DY 2 (10/1/07 – 9/30/08)	DY 3 (10/1/08 – 9/30/09)	DY 4 (10/1/09 - 9/30/10)	DY 5 (10/1/10 - 9/30/11)
TANF Children under age 1 through 20	6.7%	\$482.15	\$514.58	\$549.19	\$586.13	\$625.56
TANF Adults 21-64	6.6%	\$661.56	\$705.21	\$751.73	\$801.33	\$854.19
Disabled Adults and Children 0 – 64 voluntarily enrolled in managed care	6.12%	\$1,746	\$1,852	\$1,966	\$2,086	\$2,214
Disabled Adults and Children 0 – 64 required to enroll in managed care	6.12%	\$1,746	\$1,852	\$1,966	\$2,086	\$2,214

Eligibility Group	Trend Rate	DY 1 (10/1/06 – 9/30/07)	DY 2 (10/1/07 – 9/30/08)	DY 3 (10/1/08 – 9/30/09)	DY 4 (10/1/09 - 9/30/10)	DY 5 (10/1/10 - 9/30/11)
Aged or Disabled Elderly 65+ voluntarily enrolled in managed care	5.38%	\$1,126	\$1,186	\$1,250	\$1,318	\$1,389
Aged or Disabled Elderly 65+ required to enroll in managed care	5.38%	\$1,126	\$1,186	\$1,250	\$1,318	\$1,389

iii. The annual budget neutrality expenditure cap for the Demonstration as a whole is the sum of the projected annual expenditure caps for each EG calculated in subparagraph (i) above.

b) The overall budget neutrality expenditure cap for the 5-year demonstration period is the sum of the annual budget neutrality expenditure caps calculated in subparagraph (a) (iii) above for each of the 5 years. The Federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the State may receive for expenditures on behalf of Demonstration populations and expenditures described in paragraph 45 (e) during the Demonstration period.

60. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

<u>Demonstration Year</u>	<u>Cumulative Expenditure Cap Definition</u>	<u>Percentage</u>
Year 1	Budget neutrality expenditure cap plus	1 percent
Years 1 and 2	Combined budget neutrality expenditure caps plus	0.5 percent
Years 1 through 3	Combined budget neutrality expenditure caps plus	0.4 percent
Years 1 through 4	Combined budget neutrality expenditure caps plus	0.3 percent
Years 1 through 5	Combined budget neutrality expenditure caps plus	0 percent

61. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period the overall budget neutrality expenditure cap has been exceeded, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

X. MEDICAID PROGRAM SAVINGS MEASURES

62. **Cumulative Savings Cap.** The State is required to save \$3 billion total computable over the five-year demonstration period through specified health care reform initiatives in Section VI, paragraph 27. The \$3 billion cumulative savings cap is considered a sub cap of the budget neutrality expenditure cap calculated in Section IX.

63. **Demonstration Populations Used to Calculate the Estimated Savings.** The following Demonstration populations are used to calculate the estimated savings and are incorporated into the following EGs:

- a) **Eligibility Group 1:** TANF Child under 1 through 20 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates counties (Demonstration Population 1)
- b) **Eligibility Group 2:** TANF Adults aged 21-64 required to enroll in managed care in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates

counties (Demonstration Population 2)

- c) **Eligibility Group 4:** Disabled Adults and Children 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 4)
- d) **Eligibility Group 6:** Aged or Disabled Elderly 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006 (Demonstration Population 6)

64. **Estimated Medicaid Program Savings As a Subset of the Budget Neutrality Expenditure Cap:** The following describes the method for calculating the estimated Medicaid Program savings cap for the Demonstration:

- a) For each year of the budget neutrality agreement an annual Medicaid program savings is calculated for each EG described in paragraph 63 as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under paragraph 49 for each EG times the appropriate estimated per member per month (PM/PM) costs from the table in paragraph 59 (a)(ii).
 - ii. The annual Medicaid savings cap for the Demonstration as a whole is the sum of the projected annual expenditure caps for each EG calculated in subparagraph (i) above minus the actual expenditures for the EGs in paragraph 63 reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.
- b) For each year under the Demonstration the amount of savings attributable to hospital rightsizing will be calculated using the following method from the data provided in the annual report required by Section VII, paragraph 43:
 - i. $(\text{Base Year Medicaid discharges/enrollee} - \text{Demonstration Year Medicaid discharges/enrollee}) * (\text{Average DY Medicaid costs per discharge}) * (\text{Total DY Medicaid enrollees})$
- c) The overall Medicaid savings cap for the 5-year demonstration period is the sum of the annual Medicaid savings calculated in subparagraph (a) (ii) plus the amount calculated in subparagraph (b) for each of the 5 years. The Federal share of the overall Medicaid savings limit represents the maximum amount of FFP that the State may receive.

XI. EVALUATION OF THE DEMONSTRATION

65. **Evaluation Design.** The State must submit to CMS for approval a draft evaluation design no later than January 1, 2007. At a minimum, the draft design must include a discussion of the goals, objectives, and evaluation questions specific to the purposes of and expenditures made by the State for its health care reform activities. The draft design must discuss the outcome measures that will be used in evaluating the impact of these activities on the efficient operation of the State's health care system during the period of the Demonstration. The outcome measures below represent agreed-upon metrics under which the State and CMS can measure the shared financial benefit of the health care reforms and must be included in the evaluation design:

- Nursing home admissions - "Value of Averted Medicaid Nursing Home Admissions": For each fiscal year under the demonstration, the number of the reduction in the number of Demonstration

Year (DY) Medicaid bed-days below Base Year (BY) level * average cost per bed-day * DY Medicaid enrollees.

- Reduction in Medicaid debt payment for hospitals - “Value of Avoided Inpatient Debt Payments”: For each fiscal year under the demonstration, the reduction in the total inpatient debt per discharge from Base Year (BY) level * Medicaid discharges.
- Reduction in Medicaid debt payment for nursing homes - “Value of Avoided Nursing Home Debt Payments”: For each fiscal year under the demonstration, the reduction in the total nursing facility debt per day from Base Year (BY) level * Medicaid days.

66. **Final Evaluation Plan and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State must submit a final plan for the evaluation of the Demonstration described in paragraph 65, within 60 days of receipt of CMS comments. The State must implement the evaluation designs and report its progress on each in the quarterly reports. The State must submit to CMS a draft evaluation report 120 days prior to the expiration of the Demonstration. CMS shall provide comments within 60 days of receipt of the report. The State must submit the final report prior to the expiration date of the Demonstration.

67. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the Demonstration, the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS.

XI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION

Date - Specific	Deliverable	STC Reference
10/31/2006	Submit Plan for Fraud and Abuse Recoveries	Section VI, paragraph 30
10/31/2006	Implement Medicaid Cost Containment Initiatives	Section VI, paragraph 34
11/30/2006	Submit Baseline Data on Health Reform Initiatives	Section VI, paragraph 32
1/1/2007	Submit Evaluation Design	Section XI, paragraph 65

Date - Specific	Deliverable	STC Reference
1/31/2007	Submit Initial Report on Progress of Commission	Section VI, paragraph 37
2/1/2007	Implement Preferred Drug List	Section VI, paragraph 31
2/1/2007	Implement New Medicaid Reform Initiative	Section VI, paragraph 34
3/31/2007	Submit Report on MCO ADA Compliance Activities	Section VI, paragraph 35
1/1/2008	Implement Employee Sponsored Insurance Program	Section VI, paragraph 33
4/1/2008	Implement Single Point-of-Entry Program	Section VI, paragraph 36
7/15/2008	Submit Report on Implementation of Commission’s Recommendations	Section VI, paragraph 37
1/1/2009	Demonstrate Fraud and Abuse Recoveries of \$215 million	Section VI, paragraph 30
1/1/2009	Document Increased Rates of Private Insurance	Section VI, paragraph 33
1/1/2009	Demonstrate Fraud and Abuse Recoveries of \$322 million	Section VI, paragraph 30
1/1/2011	Demonstrate Fraud and Abuse Recoveries of \$429 million	Section VI, paragraph 30

5/31/2011	Submit Draft Evaluation Report	Section XI, paragraph 66
1/1/2012	Demonstrate Fraud and Abuse Recoveries of \$644 million	Section VI, paragraph 30
9/30/2011	Submit Final Evaluation Report	Section XI, paragraph 66

	Deliverable	STC Reference
Annual	By January 1st - Draft Report	Section VII, paragraph 43
	By December 31 st – MEQC Program Report	Section III, paragraph 14
Quarterly		
	Quarterly Operational Reports	Section VII, paragraph 42
	CMS-64 Reports	Section IX, paragraph 45
	Eligible Member Months	Section IX, paragraph 49

ATTACHMENT A

Quarterly Report Guidelines

Under Section VII, paragraph 42 of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook, as well as an updated reform metric workbook. An electronic copy of the report narrative, as well as both Microsoft Excel workbooks is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Federal-State Health Reform Partnership

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
 Demonstration Year: 1 (10/1/06 - 9/30/07)
 Federal Fiscal Quarter: 4/2007 (7/07 - 9/07)

Introduction: **Information describing the goal of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)**

Enrollment Information: Complete the following table that outlines all enrollment activity under the demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0”.

Note: Enrollment counts should be person counts for the current quarter only, not participant months.

Population Groups	Current Enrollees	# Voluntary Disenrollments	# Involuntary Disenrollments
Population 1 – TANF Child under 1 through 20 (“new” MC enrollment)			
Population 2 – TANF Child under 1 through 20 (“new” MC enrollment)			
Population 3 – Disabled Adults and Children 0-64 (“old” voluntary MC enrollment)			
Population 4 – Disabled Adults and Children 0-64 (“new” MC enrollment)			
Population 5 – Aged or Disabled Elderly (“old” voluntary MC enrollment)			
Population 6 – Aged or Disabled Elderly (“new” MC enrollment)			

Voluntary Disenrollments:

Cumulative Number of Voluntary Disenrollments in Current Demonstration Year:
 Reasons:

Involuntary Disenrollments:

Cumulative Number of Involuntary Disenrollments in Current Demonstration Year:
 Reasons:

Progress of Expansion of Mandatory Managed Care: Summarize progress towards meeting projected enrollment targets

ATTACHMENT A

Quarterly Report Guidelines

Documentation of Successful Achievement of Milestones (if any during the quarter):

Identify all activities relating to implementation of milestones required under the Demonstration, including but not limited to:

- The activities of the Commission and progress in implementing its recommendations;
- An explanation of grants, contracts or other financial arrangements entered into for purposes of implementing the health system reform efforts of this Demonstration; and
- Any other information pertinent to the health system reform efforts of this Demonstration.

Consumer Issues: A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback, issues or concerns received from the MCARP, advocates and county officials.

Financial/Budget Neutrality Developments/Issues:

Provide information on:

- Health reform expenditures – when and what
- Designated State health programs – amount of FFP claimed for the quarter
- Savings estimates
- Reform metrics

Submit both a completed reform metric workbook and an updated budget neutrality monitoring workbook

Demonstration Evaluation:

Summarize progress on evaluation design, plan and final report.

Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS:

ATTACHMENT XV

EVALUATION PLAN

New York Department of Health

Federal-State Health Reform Partnership Medicaid Section 1115 Demonstration

Start Date of Demonstration: October 1, 2006

End Date of Demonstration: September 30, 2011

As a component of the Special Terms and Conditions (STCs) for the Federal-State Health Reform Partnership (F-SHRP) Medicaid Section 1115 Demonstration (No. 11-W-00234/2), the New York State Department of Health (DOH) is required to conduct an evaluation of the demonstration and, in preparation for the evaluation, to submit this draft evaluation design for approval to the Centers for Medicare and Medicaid Services (CMS).

This evaluation design will assess the degree to which the Demonstration goals have been achieved and/or key activities have been implemented. The evaluation design includes a discussion of the Demonstration's major goals and activities, evaluation questions, and measures and data that will be used in the evaluation.

The DOH received technical assistance from a health care management consulting and research firm to prepare this evaluation plan. The DOH intends to issue a separate contract with an outside vendor for completion of the final evaluation and report. The DOH will be responsible for quarterly and annual reporting requirements.

OVERVIEW OF THE DEMONSTRATION

On September 29, 2006, CMS approved a new five-year 1115 Demonstration program entitled the Federal-State Health Reform Partnership (F-SHRP). Under this Demonstration, New York will implement a significant restructuring of its health care delivery system. The Demonstration was effective October 1, 2006.

Goals and Major Activities

The primary goals of the F-SHRP Demonstration are to improve the cost effectiveness and quality of the State's health care system and promote increased access to and coordination of care in appropriate clinical settings. To achieve these goals, the key activities of the Demonstration are as follows:

- Consolidate and "right-size" the State's health care system by reducing excess capacity in the acute care system
- Shift emphasis in long-term care from institutional-based to community-based settings
- Expand the adoption of advanced health information technology (HIT)
- Expand and improve ambulatory and primary care infrastructure
- Expand managed care to additional populations and counties in the Medicaid program

Together, these reform activities seek to achieve the desired goals of the Demonstration, resulting in long-term savings for both the State and Federal governments.

Rightsizing New York's Acute Care System

New York's acute care infrastructure is outdated and oversized and many existing facilities are highly leveraged with debt. The migration of health care services to the outpatient setting has added to the significant excess capacity that exists in the State. The State established and authorized the Commission

on Health Care Facilities in the 21st Century (Commission) to make recommendations regarding the reconfiguration of the State's health care system, including possible consolidation, closure, conversion, and restructuring of institutions and reallocation of local and statewide resources.³

Among other activities and recommendations, the Commission evaluated each hospital and nursing home in the State over the course of 18 months. Its acute care recommendations affect 57 acute care facilities, or about 25% of the State's hospitals. Recommendations include 48 acute care reconfiguration, affiliation, and conversion arrangements, and nine facility closures. Collectively, the recommendations would reduce inpatient capacity by approximately 4,200 beds, or 7 percent of the State's supply. These recommendations, if accepted by the Legislature and implemented, are aimed at reducing Medicaid inpatient hospital costs.

The F-SHRP Demonstration will place an increased emphasis on ensuring that as acute care capacity is right-sized, more services will be rendered in appropriate and cost effective clinical settings, such as outpatient settings. Right-sizing the institutional infrastructure is also expected to result in reduced inpatient utilization by reducing pressure to fill empty beds. Under this Demonstration, the DOH will retire and/or restructure hospital debt, fund operating costs necessary to downsize or close facilities, and convert unneeded acute care facilities to alternate delivery models. The Demonstration will thus expand the availability of ambulatory and primary care services, ensuring that individuals continue to have access to health care providers and services as the acute care sector is restructured.

Reforming New York's Long-Term Care System

The growth of non-institutional alternatives for long-term care services, advances in medical technology, overall improvement in the health of potential consumers and caregivers, and increasing preference for less restrictive health care alternatives is contributing to decreasing demand for traditional long term facility care. Nursing home occupancy continues to drop in most areas of the State to unprecedented levels. Today, for example, there are approximately 6,000 excess nursing home beds in New York. While occupancy has dropped, discharges/admissions have grown by 60% over the past four years, with virtually all growth in the short-stay rehabilitation categories of fewer than 90 day stays. Consequently, the average length of stay has diminished by over 40%.

The Commission's recommendations for downsizing or closing nursing homes include eliminating approximately 3,000 beds, which represents about 3 percent of the State's supply. In addition, the Commission recommended that a significant number of nursing homes should be downsized. Consistent with the Commission's recommendations, the F-SHRP Demonstration will place an increased emphasis on shifting long-term care from institutional-based to community-based settings. In addition to rightsizing activity in the long-term care sector, the Demonstration may help support implementation of a single point of entry (SPOE) system, home modification and housing accessibility initiatives, and expanded telehomecare services, all designed to respond to changing long-term care needs for the future.

Health Information Technology

Numerous studies have demonstrated the potential savings that can be achieved through expanding HIT adoption and utilization in the nation's fragmented delivery system. Greater use of HIT applications can reduce duplicative care, lower health care administration costs, and minimize errors in care. However, moving forward on major HIT initiatives will require significant financial investments. New York has enacted the HEAL NY (Health Care Efficiency and Affordability Law for New Yorkers) program to, among other activities, expand the use of e-prescribing, develop and expand the use of electronic medical records, and facilitate the development, implementation and application of interoperable health information exchange across care settings throughout New York.

HEAL NY makes grants to acute and long-term care facilities that demonstrate a commitment to investing in the restructuring and reconfiguration of their facilities to improve the delivery of quality care

³ "A Plan to Stabilize and Strengthen New York's Health Care System." Final Report of the Commission on Health Care Facilities in the 21st Century. December 2006. URL: http://www.nyhealthcarecommission.org/final_report.htm.

to patients. Funded projects may include those that seek to expand the adoption and use of health IT applications in New York and promote interoperable health information exchange across care settings throughout the State.

Expansion of Medicaid Managed Care

The current mandatory managed care program operated by New York (under the Partnership Plan Demonstration, No. 11-W-00114/2) provides Medicaid State Plan benefits through mandated comprehensive managed care organizations to Medicaid recipients that live in New York City and 23 other counties in the following eligibility categories.

State plan mandatory and optional groups	FPL level and/or other qualifying criteria
Children under age 1	Up to 200 % FPL
Children 1 through 5	Up to 133% FPL
Children 6 through 18	Up to 100% FPL
Children 19-20	Monthly income standard (determined annually)
Adult (21-64) AFDC-related family members	Monthly income standard (determined annually)

Under the F-SHRP Demonstration, recipients that fall within the above categories living in the following 14 counties will be required to enroll in managed care organizations: Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates.

In addition, under the F-SHRP Demonstration, implementation of mandatory enrollment of the SSI population will be accelerated and expanded to also incorporate those individuals who are seriously and persistently mentally ill (SPMI).

New York has been able to document significant savings resulting from the implementation of the Medicaid managed care program under the Partnership Plan Demonstration. Those results are expected to continue and the State is working actively on initiatives to expand the Medicaid managed care program to populations currently not enrolled. F-SHRP reforms seek to build on the success of the Partnership Plan Demonstration to attain additional cost savings as well as improved quality of care.

TECHNICAL APPROACH

The primary goals of the F-SHRP Demonstration are to improve the cost effectiveness, efficiency, and quality of the State’s health care system and promote increased access and coordination of care in appropriate clinical settings. To accomplish these goals, the Demonstration includes several key activities, including restructuring the State’s acute and long-term care infrastructure, supporting expanded ambulatory care initiatives, investing in health information technology, and expanding managed care services to more counties and Medicaid beneficiaries. This evaluation plan will assess the degree to which the key goals of the Demonstration have been achieved and/or the key activities of the Demonstration have been implemented.

Evaluation Plan Approach

The process of designing the evaluation plan first involved identifying and documenting the Demonstration’s key goals and activities, which were included in the State’s Demonstration proposal and the Special Terms and Conditions.

With key goals and activities identified, the process of designing the evaluation plan involved selecting several evaluation questions that correspond to each of the major Demonstration goals and activities. The evaluation itself will seek to answer the evaluation questions, which in turn will assess the degree to which the Demonstration has been effective in implementing the key activities identified, directly

achieving the goals of the Demonstration, or both.

The specific evaluation questions to be addressed by the evaluation were based on the following criteria:

- 4) Potential for improvement, consistent with the key goals of the Demonstration
- 5) Potential for measurement, including (where possible and relevant) baseline measures that can help to isolate the effects of Demonstration initiatives and activities over time
- 6) Potential to coordinate with the DOH's ongoing performance evaluation and monitoring efforts

Once research questions were selected to address the Demonstration's major program goals and activities, specific variables and measures were then identified to correspond to each research question. Finally, a process was developed for identifying data sources that are most appropriate and efficient in answering each of the evaluation questions.

Analysis Plan

While the Demonstration seeks to reform New York's health care delivery system, observed changes may be attributed to the Demonstration itself and/or external factors, including other State- or national-level policy or market changes or trends. The evaluation team will develop a theoretical framework depicting how specific Demonstration goals, tasks, and activities are causally connected. This theoretical framework, which may include a logic model, will incorporate any known or possible external influences to the extent possible (such as policy changes or market shifts) and their potential interactions with the Demonstration's goals and activities.

The theoretical framework will be used as a reference for the evaluation team in isolating the degree to which the Demonstration is associated with observed changes in relevant outcomes. Specifically, the evaluation team will seek to isolate the effects of the Demonstration on the observed outcomes in several ways:

- 4) To the extent possible, the evaluation team will gather and describe credible evidence that attempts to isolate the Demonstration's contribution to any observed outcomes as well as describe the relative contributions of other factors influencing those outcomes. This will include documenting any relevant legal, regulatory, or policy changes or other trends – including the sequence, scope, and duration of such changes – at both a State and national level that are likely to influence the observed outcomes.
- 5) Where possible and relevant, the evaluation will incorporate baseline measures for each of the selected variables included in the evaluation. Data for each of the targeted variables and measures will be collected regularly so that changes in outcome measures and variables can be observed on a longitudinal basis.
- 6) The evaluation will compare rates of performance and measures with State and national benchmarks, where relevant and feasible. Incorporating benchmark measures will allow for external comparisons of Demonstration measures to State and national trends, further isolating the impacts of the Demonstration by controlling for external factors influencing the observed outcomes.

The evaluation features described above (analysis of qualitative contextual information, the use of baseline measures, ongoing data collection, and benchmarking) represent quasi-experimental means by which the evaluation team will determine the effects of the Demonstration on the health care system in New York. Evaluation conclusions will include key findings associated with individual research questions addressed as well as integrated information combining the results of individual evaluation questions to make broad conclusions about the effects of the Demonstration as a whole.

In addition, the evaluation will also include specific recommendations of best practices and lessons learned that can be useful for DOH, other States, and CMS. Moreover, to the extent possible, the evaluation team will integrate and/or compare evaluation conclusions and recommendations to previous studies or evaluations of relevance.

The DOH will contract with an EQRO to conduct a federally-required review of Managed Care Entities (MCE) as defined in 42 CFR 438 Subpart E. As the expansion of managed care to selected populations and counties is an important component of this Demonstration, the findings from EQRO activities and from ongoing internal monitoring of managed care activities will be made available, as necessary, to assist the vendor selected to conduct the evaluation and write the interim and final reports.

EVALUATION GOALS, ACTIVITIES, MEASURES, AND DATA

This section describes the evaluation plan's key goals, activities, evaluation questions, measures/variables, and data sources.

GOAL 1: ACUTE CARE RESTRUCTURING

Goal

Goal 1 of the Demonstration is to create a more efficient acute care system in New York State that promotes access to high quality, cost effective care.

Activities

To achieve Goal 1, the Demonstration will facilitate the implementation of Commission recommendations to modify the State's existing acute care infrastructure. This will involve retiring and/or restructuring hospital debt, funding operating costs necessary to downsize or close facilities, and converting unneeded acute care facilities to alternate delivery models. The Demonstration will also place an increased emphasis on ensuring that more services are rendered in non-acute clinical settings by expanding ambulatory and primary care services.

Key Evaluation Questions

2. To what extent has the Demonstration resulted in reductions in the number of acute care facilities and beds in New York State?
 - Outcome measures and variables: Number and type of facilities eliminated or restructured; Number of beds associated with eliminated/restructured facilities
3. What impact has acute care restructuring had on the capacity and occupancy of remaining facilities?
 - Outcome measures and variables: Average capacity and occupancy of remaining facilities
4. To what extent has reduced excess bed capacity resulted in reductions in hospital admissions?
 - Outcome measures and variables: "Value of averted hospital admissions" = The reduction in the number of Demonstration Year (DY) Medicaid discharges per enrollee below Base Year (BY) level * average cost per discharge * DY Medicaid enrollees
5. To what extent have acute care facilities been converted to alternate uses?
 - Outcome measures and variables: Number of acute care facilities converted to alternate services/facilities, including innovative approaches to emergency services in rural areas and other ambulatory care uses
6. What have been the impacts of acute care restructuring on access to primary and specialty care?
 - Outcome measures and variables: Physician participation in Medicaid managed care program, by specialty; number of primary and specialty care visits PMPM
7. To what extent has acute care restructuring reduced financial burdens associated with excess capacity?
 - Outcome measures and variables: Debt retirement/restructuring of affected facilities; debt and type of debt associated with remaining institutions; "Value of avoided inpatient debt payments" = the reduction in the total inpatient debt per discharge from Base Year (BY) level * Medicaid discharges

Data Sources

- Medicaid Management Information System (MMIS)
- Medicaid Encounter Data System (MEDS)
- HPN
- Internal tracking system which includes but is not limited to Institutional Cost Reports, the SPARCS database and the Certificate of Need database.

The internal tracking system along with the other data sources will permit the DOH to conduct rigorous analysis, data reporting, and tracking not only of closure and wind-down costs and volume shifts, but also measuring and monitoring projected versus achieved savings and benefits. These systems will be modified and synthesized with other internal data sources to create a customized tracking system useful for the F-SHRP Demonstration evaluation.

This tracking system will also be important in closely monitoring access to care issues, allowing for adjustments in available resources should circumstances warrant. Factors to be monitored in the DOH's internal tracking system will include claims, acute and long-term care beds, occupancy and capacity of remaining facilities, cost and revenue per case, outpatient utilization patterns, payor source trends, and other relevant measures. The tracking system will be refined and improved as the State progresses through rightsizing activities.

GOAL 2: LONG-TERM CARE RESTRUCTURING

Goal

Goal 2 of the Demonstration is to create a more efficient long-term care system in New York State that is consistent with consumers' increasing preference for less restrictive community-based settings compared to more traditional long-term care models.

Activities

To achieve Goal 2, the Demonstration will facilitate the implementation of Commission recommendations to rightsize the State's long-term care infrastructure. In addition to closing and/or modifying facilities, this will involve placing an increased emphasis on shifting long-term care from institutional-based to community-based settings.

Key Evaluation Questions

1. To what extent has the Demonstration resulted in reductions in and reconfigurations of long-term care facilities and services?
 - *Outcome measures and variables:* Number and types of facilities eliminated or restructured; number of beds associated with eliminated/restructured facilities
2. What have been the impacts of long-term care restructuring on the availability and use of home and community based services?
 - *Outcome measures and variables:* Home and community based utilization patterns
3. To what extent has the Demonstration yielded reductions in nursing home debt?
 - *Outcome measures and variables:* Comparison of total nursing home debt reported annually (adjusting for new debt) to base year debt..Value of Avoided Nursing Home Debt Payments" = the reduction in the total nursing facility debt per day from Base Year (BY) level * Medicaid days
4. To what extent have Medicaid nursing home admissions been averted as a result of the Demonstration?
 - *Outcome measures and variables:* "Value of averted Medicaid nursing home admissions" = The reduction in the number of Demonstration Year (DY) Medicaid bed-days per enrollee below Base Year (BY) level * average cost per bed-day * DY Medicaid enrollees

Data Sources

- Medicaid Management Information System (MMIS)
- Medicaid Encounter Data System (MEDS)
- Institutional Cost Reports

GOAL 3: HEALTH INFORMATION TECHNOLOGY

Goal

Goal 3 of the Demonstration is to improve quality of care, reduce medical errors, and increase efficiency in New York State's health care system.

Activities

To achieve Goal 3, the Demonstration will seek to expand the use of e-prescribing, develop and expand the use of electronic medical records, and facilitate the development, implementation and application of interoperable health information exchange across care settings throughout New York.

Key Evaluation Questions

1. What Demonstration activities have aimed to improve the adoption or promote the use of e-prescribing?
2. What Demonstration activities have aimed to improve the adoption or promote the use of electronic medical records (EMRs)?
3. What Demonstration activities have aimed to promote system-wide data sharing and gathering to support higher quality care, transparency, and error reduction?
 - *Outcome measures and variables:* HEAL NY grantmaking activity related to the goals of the Demonstration; data from HEAL NY grantees on changes in use of e-prescribing, EMRs, and data sharing and gathering, and other relevant activities

Data Sources

- HEAL NY grant activity data (description below)
- HEAL NY grantee reports (description below)

A key goal of HEAL NY is to identify and support development and investment in HIT projects on a regional and State level. The DOH maintains detailed records of the types of grants made and their related activities. The HEAL NY grantmaking and contractual reporting requirements will provide the necessary data to monitor and track the degree to which the Demonstration's goals regarding HIT adoption are being achieved. This will include the types of grants made as well as any relevant outcomes identified by grantees associated with the goals of the Demonstration in the area of HIT.

GOAL 4: MANAGED CARE EXPANSION

Goal

Goal 4 of the Demonstration is to slow the growth of Medicaid expenditures through reduced medical costs and greater administrative efficiencies, achieve more efficient service delivery for Medicaid beneficiaries, and promote high quality integrated systems of care.

Task

To achieve Goal 4 of the Demonstration, the State will expand comprehensive managed care services to 14 additional counties and also extend mandatory managed care to the aged and blind from the Partnership Plan Demonstration to the F-SHRP Demonstration.

Key Evaluation Questions

1. How many aged and disabled Medicaid beneficiaries (previously participating in the Partnership Plan) were affected by the F-SHRP Demonstration?
 - *Outcome measures and variables:* Number of beneficiaries affected by transfer of authority, by beneficiary type, age category, and county
2. How many Medicaid beneficiaries were affected by the expansion of mandatory managed care enrollment to 14 additional counties?
 - *Outcome measures and variables:* Number of beneficiaries enrolled in Medicaid managed care, by beneficiary type, age category, and county

Data

- MMIS

Table 1: Evaluation of the F-SHRP Demonstration

	Research Questions	Outcome Measures and Variables	Data Sources
Goal 1	Acute Care Restructuring		
PRE	Establish baseline measurements in variables described below		
1	To what extent has the Demonstration resulted in reductions in the number of acute care facilities and beds?	Number and type of facilities eliminated or restructured; Number of beds associated with eliminated/restructured facilities	Internal DOH Tracking System
2	What impact has acute care restructuring had on the capacity and occupancy of remaining facilities?	Average capacity and occupancy of remaining facilities	Internal DOH Tracking System
3	To what extent have acute care facilities been converted to alternate uses?	Number of acute care facilities converted to alternate services/facilities, e.g., innovative approaches to emergency services in rural areas and other ambulatory care uses	Internal DOH Tracking System
4	What have been the impacts of acute care restructuring on access to primary and specialty care?	Physician participation in Medicaid managed care program, by specialty; number of primary and specialty care visits PMPM	MMIS; HPN Internal DOH Tracking System
5*	To what extent has acute care restructuring reduced financial burdens associated with excess capacity?	Debt retirement/restructuring of affected facilities; debt and type of debt associated with remaining institutions "Value of avoided inpatient debt payments" = the reduction in the total inpatient debt per discharge from Base Year (BY) level * Medicaid discharges	Internal DOH Tracking System
6*	To what extent has reduced excess bed capacity resulted in reductions in hospital admissions?	"Value of averted hospital admissions" = The reduction in the number of Demonstration Year discharges per enrollee below Base Year (BY) level * average cost per discharge * DY Medicaid enrollees	MMIS; Internal DOH Tracking System

Goal 2 Long-Term Care Restructuring			
PRE	Establish baseline measurements in variables described below		
1	To what extent has the Demonstration resulted in reductions in and reconfigurations of long-term care facilities and services?	Number and types of facilities eliminated or restructured; number of beds associated with eliminated/restructured facilities	Internal DOH Tracking System
2	What have been the impacts of long-term care restructuring on the availability and use of home and community based services?	Home and community based utilization patterns	Internal DOH Tracking System
3*	To what extent has the Demonstration yielded reductions in debt payments for nursing homes?	“Value of Avoided Nursing Home Debt Payments” = the reduction in the total nursing facility debt per day from Base Year (BY) level * Medicaid days	Internal DOH Tracking System
4*	To what extent have Medicaid nursing home admissions been averted as a result of the Demonstration?	“Value of averted Medicaid nursing home admissions” = The reduction in the number of Demonstration Year (DY) Medicaid bed-days per enrollee below Base Year (BY) level * average cost per bed-day * DY Medicaid enrollees	MMIS; Internal DOH Tracking System
Goal 3 Health Information Technology			
PRE	Establish baseline measurements in variables described below		
1	What Demonstration activities have aimed to improve the adoption or promote the use of e-prescribing?	HEAL NY grantmaking activity related to the goals of the Demonstration; data from HEAL NY grantees on changes in use of e-prescribing, EMRs, and data sharing and gathering	HEAL NY grant activity data; HEAL NY grantee reports
2	What Demonstration activities have aimed to improve the adoption or promote the use of electronic medical records (EMRs)?		
3	What Demonstration activities have aimed to promote systemwide data sharing and gathering to support higher quality care, transparency, and error reduction?		
Goal 4 Managed Care Expansion			
PRE	Establish baseline measurements in variables described below		
1	How many aged and disabled Medicaid beneficiaries (previously participating in the Partnership Plan) did the F-SHRP Demonstration affect?	Number of beneficiaries affected, by beneficiary type, age category, and county	MMIS
2	How many Medicaid beneficiaries were affected by the expansion of mandatory managed care enrollment to 14 additional counties?		

*Outcome measures were included in the Special Terms and Conditions

ATTACHMENT XVI

CONTRACT APPENDICES

Appendix A: Standard Clauses for NYS Contracts

STANDARD CLAUSES FOR NYS CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licensor, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the previous consent, in writing, of the State and any attempts to assign the contract without the State's written consent are null and void. The Contractor may, however, assign its right to receive payment without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds \$50,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds \$10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed \$85,000 (State Finance Law Section 163.6.a).

4. WORKERS' COMPENSATION BENEFITS. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. NON-DISCRIMINATION REQUIREMENTS. To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex, national origin, sexual orientation, age, disability, genetic predisposition or carrier status, or marital status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of \$50.00 per person per day for any violation of Section

220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. WAGE AND HOURS PROVISIONS. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law.

7. NON-COLLUSIVE BIDDING CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds \$5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of setoff any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor

within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY

NOTIFICATION. (a) **FEDERAL EMPLOYER IDENTIFICATION NUMBER and/or FEDERAL SOCIAL SECURITY NUMBER.** All invoices or New York State standard vouchers submitted for payment for the sale of goods or services or the lease of real or personal property to a New York State agency must include the payee's identification number, i.e., the seller's or lessor's identification number. The number is either the payee's Federal employer identification number or Federal social security number, or both such numbers when the payee has both such numbers. Failure to include this number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or New York State standard voucher, must give the reason or reasons why the payee does not have such number or numbers.

(b) **PRIVACY NOTIFICATION.** (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law.

(2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in New York State's Central Accounting System by the Director of Accounting Operations, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR

MINORITIES AND WOMEN. In accordance with Section 312 of the Executive Law, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of \$25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of \$100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of \$100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a", "b", and "c" above, in every subcontract over \$25,000.00 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. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State; or (iii) banking services, insurance policies or the sale of securities. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Governor's Office of Minority and Women's Business Development pertaining hereto.

13. CONFLICTING TERMS. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. GOVERNING LAW. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL

HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of State Finance Law §165. (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any

governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts. Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business
30 South Pearl St -- 7th Floor
Albany, New York 12245
Telephone: 518-292-5220
Fax: 518-292-5884
<http://www.empire.state.ny.us>

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development
30 South Pearl St -- 2nd Floor
Albany, New York 12245
Telephone: 518-292-5250
Fax: 518-292-5803
<http://www.empire.state.ny.us>

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than \$1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document

these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. RECIPROCITY AND SANCTIONS PROVISIONS. Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 15, 2002, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii. Contact NYS Department of Economic Development for a current list of jurisdictions subject to this provision.

22. PURCHASES OF APPAREL. In accordance with State Finance Law 162 (4-a), the State shall not purchase any apparel from any vendor unable or unwilling to certify that: (i) such apparel was manufactured in compliance with all applicable labor and occupational safety laws, including, but not limited to, child labor laws, wage and hours laws and workplace safety laws, and (ii) vendor will supply, with its bid (or, if not a bid situation, prior to or at the time of signing a contract with the State), if known, the names and addresses of each subcontractor and a list of all manufacturing plants to be utilized by the bidder.

APPENDIX D
GENERAL SPECIFICATIONS

- A. By signing the "Bid Form" each bidder attests to its express authority to sign on behalf of this company or other entity and acknowledges and accepts that:
- All specifications, general and specific appendices, including Appendix-A, the Standard Clauses for all New York State contracts, and all schedules and forms contained herein will become part of any contract entered, resulting from the Request for Proposal. Anything which is not expressly set forth in the specification, appendices and forms and resultant contract, but which is reasonable to be implied, shall be furnished and provided in the same manner as if specifically expressed.
- B. The work shall be commenced and shall be actually undertaken within such time as the Department of Health may direct by notice, whether by mail, telegram, or other writing, whereupon the undersigned will give continuous attention to the work as directed, to the end and with the intent that the work shall be completed within such reasonable time or times, as the case may be, as the Department may prescribe.
- C. The Department reserves the right to stop the work covered by this proposal and the contract at any time that the Department deems the successful bidder to be unable or incapable of performing the work to the satisfaction of the Department and in the event of such cessation of work, the Department shall have the right to arrange for the completion of the work in such manner as the Department may deem advisable and if the cost thereof exceeds the amount of the bid, the successful bidder and its surety be liable to the State of New York for any excess cost on account thereof.
- D. Each bidder is under an affirmative duty to be informed by personal examination of the specifications and location of the proposed work and by such other means as it may select, of character, quality, and extent of work to be performed and the conditions under which the contract is to be executed.
- E. The Department of Health will make no allowances or concession to a bidder for any alleged misunderstanding or deception because of quantity, quality, character, location or other conditions.
- F. The bid price is to cover the cost of furnishing all of the said services, materials, equipment, and labor to the satisfaction of the Department of Health and the performance of all work set forth in said specifications.
- G. The successful bidder will be required to complete the entire work, or any part thereof as the case may be, to the satisfaction of the Department of

Health in strict accordance with the specifications and pursuant to a contract therefore.

- H. Contractor will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.
- I. **Non-Collusive Bidding**
By submission of this proposal, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of their knowledge and belief:
- a. The prices of this bid have been arrived at independently without collusion, consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any competitor;
 - b. Unless otherwise required by law, the prices which have been quoted in this bid have not been knowingly disclosed by the bidder and will not knowingly be disclosed by the bidder prior to opening, directly or indirectly to any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition;
 - c. No attempt has been made or will be made by the bidder to induce any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition.

NOTE: Chapter 675 of the Laws of New York for 1966 provides that every bid made to the state or any public department, agency or official thereof, where competitive bidding is required by statute, rule or regulation, for work or services performed or to be performed or goods sold or to be sold, shall contain the foregoing statement subscribed by the bidder and affirmed by such bidder as true under penalties of perjury.

A bid shall not be considered for award nor shall any award be made where (a), (b) and (c) above have not been complied with; provided however, that if in any case the bidder cannot make the foregoing certification, the bidder shall so state and shall furnish with the bid a signed statement which sets forth in detail the reasons therefore. Where (a), (b) and (c) above have not been complied with, the bid shall not be considered for award nor shall any award be made unless the head of the purchasing unit of the state, public department or agency to which the bid is made or its designee, determines that such disclosure was not made for the purpose of restricting competition.

The fact that a bidder has published price lists, rates, or tariffs covering items being procured, has informed prospective customers of proposed or pending publication of new or revised price lists for such items, or has sold the same items to other customers at the same price being bid, does not constitute, without more, a disclosure within the meaning of the above quoted certification.

Any bid made to the State or any public department, agency or official thereof by a corporate bidder for work or services performed or to be performed or goods, sold or to be sold, where competitive bidding is required by statute, rule or regulation and where such bid contains the certification set forth above shall be deemed to have been authorized by the board of directors of the bidder, and such authorization shall be deemed to include the signing and submission of the bid and the inclusion therein of the certificate as to non-collusion as the act and deed of the corporation.

- J. A bidder may be disqualified from receiving awards if such bidder or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its or its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.
- K. The Department reserves the right to make awards within ninety (90) days after the date of the bid opening, during which period bids shall not be withdrawn unless the bidder distinctly states in the bid that acceptance thereof must be made within a shorter specified time.
- L. **Work for Hire Contract**
Any contract entered into resultant from this request for proposal will be considered a "Work for Hire Contract." The Department will be the sole owner of all source code and any software which is developed or included in the application software provided to the Department as a part of this contract.
- M. **Technology Purchases Notification --** The following provisions apply if this Request for Proposal (RFP) seeks proposals for "Technology"
 - 1. For the purposes of this policy, "technology" applies to all services and commodities, voice/data/video and/or any related requirement, major software acquisitions, systems modifications or upgrades, etc., that result in a technical method of achieving a practical purpose or in improvements of productivity. The purchase can be as simple as an order for new or replacement personal computers, or for a consultant to design a new system, or as complex as a major systems improvement or innovation that changes how an agency conducts its business practices.

2. If this RFP results in procurement of software over \$20,000, or of other technology over \$50,000, or where the department determines that the potential exists for coordinating purchases among State agencies and/or the purchase may be of interest to one or more other State agencies, PRIOR TO AWARD SELECTION, this RFP and all responses thereto are subject to review by the New York State Office for Technology.
3. Any contract entered into pursuant to an award of this RFP shall contain a provision which extends the terms and conditions of such contract to any other State agency in New York. Incorporation of this RFP into the resulting contract also incorporates this provision in the contract.
4. The responses to this RFP must include a solution to effectively handle the turn of the century issues related to the change from the year 1999 to 2000.

N. YEAR 2000 WARRANTY

1. Definitions

For purposes of this warranty, the following definitions shall apply:

- a. Product shall include, without limitation: any piece or component of equipment, hardware, firmware, middleware, custom or commercial software, or internal components or subroutines therein which perform any date/time data recognition function, calculation, comparing or sequencing. Where services are being furnished, e.g. consulting, systems integration, code or data conversion or data entry, the term Product shall include resulting deliverables.
- b. Vendor's Product shall include all Product delivered under this Agreement by Vendor other than Third Party Product.
- c. Third Party Product shall include products manufactured or developed by a corporate entity independent from Vendor and provided by Vendor on a non-exclusive licensing or other distribution Agreement with the third party manufacturer. Third Party Product does not include product where Vendor is: a) corporate subsidiary or affiliate of the third party manufacturer/developer; and/or b) the exclusive re-seller or distributor of product manufactured or developed by said corporate entity.

2. Warranty Disclosure

At the time of bid, Product order or Product quote, Vendor is required to disclose the following information in writing to Authorized User:

- a. For Vendor Product and for Products (including, but not limited to, Vendor and/or Third Party Products and/or Authorized User's Installed Product) which have been specified to perform as a system: Compliance or non-compliance of the Products individually or as a system with the Warranty Statement set forth below; and
- b. For Third Party Product Not Specified as Part of a System: Third Party Manufacturer's statement of compliance or non-compliance of any Third Party Product being delivered with Third Party Manufacturer/Developer's Year 2000 warranty. If such Third Party Product is represented by Third Party Manufacturer/Developer as compliant with Third Party Manufacturer/Developer's Year 2000 Warranty, Vendor shall pass through said third party warranty from the third party manufacturer to the Authorized User but shall not be liable for the testing or verification of Third Party's compliance statement. .

An absence or failure to furnish the required written warranty disclosure shall be deemed a statement of compliance of the product(s) or system(s) in question with the year 2000 warranty statement set forth below.

3. Warranty Statement

Year 2000 warranty compliance shall be defined in accordance with the following warranty statement:

Vendor warrants that Product(s) furnished pursuant to this Agreement shall, when used in accordance with the Product documentation, be able to accurately process date/time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000, including leap year calculations. Where a purchase requires that specific Products must perform as a package or system, this warranty shall apply to the Products as a system.

In the event of any breach of this warranty, Vendor shall restore the Product to the same level of performance as warranted herein, or repair or replace the Product with conforming Product so as to minimize interruption to Authorized User's ongoing business processes, time being of the essence, at Vendor's sole cost and expense. This warranty does not extend to correction of Authorized

User's errors in data entry or data conversion.

This warranty shall survive beyond termination or expiration of the Agreement.

Nothing in this warranty shall be construed to limit any rights or remedies otherwise available under this Agreement.

O. No Subcontracting

Subcontracting by the contractor shall not be permitted except by prior written approval and knowledge of the Department of Health.

P. Superintendence by Contractor

The Contractor shall have a representative to provide supervision of the work which Contractor employees are performing to ensure complete and satisfactory performance with the terms of the Contract. This representative shall also be authorized to receive and put into effect promptly all orders, directions and instructions from the Department of Health. A confirmation in writing of such orders or directions will be given by the Department when so requested from the Contractor.

Q. Sufficiency of Personnel and Equipment

If the Department of Health is of the opinion that the services required by the specifications cannot satisfactorily be performed because of insufficiency of personnel, the Department shall have the authority to require the Contractor to use such additional personnel, to take such steps necessary to perform the services satisfactorily at no additional cost to the State.

R. Experience Requirements

The Contractor shall submit evidence to the satisfaction of the Department that it possesses the necessary experience and qualifications to perform the type of services required under this contract and must show that it is currently performing similar services. The Contractor shall submit at least two references to substantiate these qualifications.

S. Contract Amendments

This agreement may be amended by written agreement signed by the parties and subject to the laws and regulations of the State pertaining to contract amendments. This agreement may not be amended orally. The contractor shall not make any changes in the scope of work as outlined herein at any time without prior authorization in writing from the Department of Health and without prior approval in writing of the amount of compensation for such changes.

T. Provisions Upon Default

1. In the event that the Contractor, through any cause, fails to perform any of the terms, covenants or promises of this agreement, the Department

acting for and on behalf of the State, shall thereupon have the right to terminate this agreement by giving notice in writing of the fact and date of such termination to the Contractor

2. If, in the judgement of the Department of Health, the Contractor acts in such a way which is likely to or does impair or prejudice the interests of the State, the Department acting on behalf of the State, shall thereupon have the right to terminate this agreement by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgement of the State Comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was engaged in at the time of such termination, subject to audit by the State Comptroller.

U. Termination Provision

Upon termination of this agreement, the following shall occur:

1. Contractor shall make available to the State for examination all data, records and reports relating to this Contract; and
2. Except as otherwise provided in the Contract, the liability of the State for payments to the Contractor and the liability of the Contractor for services hereunder shall cease.

V. Conflicts

If, in the opinion of the Department of Health, (1) the specifications conflict, or (2) if the specifications are not clear as to (a) the method of performing any part of the work, or as to (b) the types of materials or equipment necessary, or as to (c) the work required to be done in every such situation, the Contractor shall be deemed to have based his bid upon performing the work and furnishing materials or equipment in the most inexpensive and efficient manner. If such conflicts and/or ambiguities arise, the Department of Health will furnish the Contractor supplementary information showing the manner in which the work is to be performed and the type or types of material or equipment that shall be used.

W. MINORITY AND WOMEN OWNED BUSINESS POLICY STATEMENT

The New York State Department of Health recognizes the need to take affirmative action to ensure that Minority and Women Owned Business Enterprises are given the opportunity to participate in the performance of the Department of Health's contracting program. This opportunity for full participation in our free enterprise system by traditionally, socially and economically disadvantaged persons is essential to obtain social and economic equality and improve the functioning of the State economy.

It is the intention of the New York State Department of Health to fully execute the mandate of Executive Law, Article 15-A and provide Minority and Women Owned Business Enterprises with equal opportunity to bid on contracts awarded by this agency in accordance with the State Finance Law.

To implement this affirmative action policy statement, the contractor agrees to file with the Department of Health within 10 days of notice of award, a staffing plan of the anticipated work force to be utilized on this contract or, where required, information on the contractor's total work force, including apprentices, broken down by specified ethnic background, gender, and Federal occupational categories or other appropriate categories specified by the Department. The form of the staffing plan shall be supplied by the Department.

After an award of this contract, the contractor agrees to submit to the Department a work force utilization report, in a form and manner required by the Department, of the work force actually utilized on this contract, broken down by specified ethnic background, gender and Federal occupational categories or other appropriate categories specified by the Department.

X. Contract Insurance Requirements

1. The successful bidder must without expense to the State procure and maintain, until final acceptance by the Department of Health of the work covered by this proposal and the contract, insurance of the kinds and in the amounts hereinafter provided, in insurance companies authorized to do such business in the State of New York covering all operations under this proposal and the contract, whether performed by it or by subcontractors. Before commencing the work, the successful bidder shall furnish to the Department of Health a certificate or certificates, in a form satisfactory to the Department, showing that it has complied with the requirements of this section, which certificate or certificates shall state that the policies shall not be changed or canceled until thirty days written notice has been given to the Department. The kinds and amounts of required insurance are:
 - a. A policy covering the obligations of the successful bidder in accordance with the provisions of Chapter 41, Laws of 1914, as amended, known as the Workers' Compensation Law, and the contract shall be void and of no effect unless the successful bidder procures such policy and maintains it until acceptance of the work (reference Appendix E).
 - b. Policies of Bodily Injury Liability and Property Damage Liability Insurance of the types hereinafter specified, each within limits of not less than \$500,000 for all damages arising out of bodily injury,

including death at any time resulting therefrom sustained by one person in any one occurrence, and subject to that limit for that person, not less than \$1,000,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by two or more persons in any one occurrence, and not less than \$500,000 for damages arising out of damage to or destruction of property during any single occurrence and not less than \$1,000,000 aggregate for damages arising out of damage to or destruction of property during the policy period.

- i. Contractor's Liability Insurance issued to and covering the liability of the successful bidder with respect to all work performed by it under this proposal and the contract.
- ii. Protective Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this proposal and the contract, by the successful bidder or by its subcontractors, including omissions and supervisory acts of the State.
- iii. Automobile Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this proposal and the contract, by the successful bidder or by its subcontractors, including omissions and supervisory acts of the State.

Y. Certification Regarding Debarment and Suspension

Regulations of the Department of Health and Human Services, located at Part 76 of Title 45 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in federal programs and activities. Executive Order 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government-wide system for nonprocurement debarment and suspension. Executive Order 12689 extends the debarment and suspension policy to procurement activities of the federal government. A person who is debarred or suspended by a federal agency is excluded from federal financial and non-financial assistance and benefits under federal programs and activities, both directly (primary covered transaction) and indirectly (lower tier covered transactions). Debarment or suspension by one federal agency has government-wide effect.

Pursuant to the above-cited regulations, the New York State Department of Health (as a participant in a primary covered transaction) may not knowingly do business with a person who is debarred, suspended, proposed for debarment, or subject to other government-wide exclusion (including any exclusion from Medicare and State health care program

participation on or after August 25, 1995), and the Department of Health must require its prospective contractors, as prospective lower tier participants, to provide the certification in Appendix B to Part 76 of Title 45 CFR, as set forth below:

1. APPENDIX B TO PART 76-CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS

Instructions for Certification

- a. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.
- b. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
- c. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
- d. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered Transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
- e. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

- f. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled “Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction,” without modification, in all lower tier covered transactions.
 - g. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of parties Excluded from Federal Procurement and Nonprocurement Programs.
 - h. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
 - i. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
2. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions
- a. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily exclude from participation in this transaction by any Federal department agency.
 - b. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Z. Confidentiality Clauses

1. Any materials, articles, papers, etc., developed by the CONTRACTOR under or in the course of performing this AGREEMENT shall contain the following, or similar acknowledgment: "Funded by the New York State Department of Health". Any such materials must be reviewed and approved by the STATE for conformity with the policies and guidelines for the New York State Department of Health prior to dissemination and/or publication. It is agreed that such review will be conducted in an expeditious manner. Should the review result in any unresolved disagreements regarding content, the CONTRACTOR shall be free to publish in scholarly journals along with a disclaimer that the views within the Article or the policies reflected are not necessarily those of the New York State Department of Health. The Department reserves the right to disallow funding for any educational materials not approved through its review process.
2. Any publishable or otherwise reproducible material developed under or in the course of performing this AGREEMENT, dealing with any aspect of performance under this AGREEMENT, or of the results and accomplishments attained in such performance, shall be the sole and exclusive property of the STATE, and shall not be published or otherwise disseminated by the CONTRACTOR to any other party unless prior written approval is secured from the STATE or under circumstances as indicated in paragraph 1 above. Any and all net proceeds obtained by the CONTRACTOR resulting from any such publication shall belong to and be paid over to the STATE. The STATE shall have a perpetual royalty-free, non-exclusive and irrevocable right to reproduce, publish or otherwise use, and to authorize others to use, any such material for governmental purposes.
3. No report, document or other data produced in whole or in part with the funds provided under this AGREEMENT may be copyrighted by the CONTRACTOR or any of its employees, nor shall any notice of copyright be registered by the CONTRACTOR or any of its employees in connection with any report, document or other data developed pursuant to this AGREEMENT.
4. All reports, data sheets, documents, etc. generated under this contract shall be the sole and exclusive property of the Department of Health. Upon completion or termination of this AGREEMENT the CONTRACTOR shall deliver to the Department of Health upon its demand all copies of materials relating to or pertaining to this AGREEMENT. The CONTRACTOR shall have no right to disclose

or use any of such material and documentation for any purpose whatsoever, without the prior written approval of the Department of Health or its authorized agents.

5. The CONTRACTOR , its officers, agents and employees and subcontractors shall treat all information, which is obtained by it through its performance under this AGREEMENT, as confidential information to the extent required by the laws and regulations of the United States and laws and regulations of the State of New York.
6. All subcontracts shall contain provisions specifying:
 - a. that the work performed by the subcontractor must be in accordance with the terms of this AGREEMENT, and
 - b. that the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in the AGREEMENT between the STATE and the CONTRACTOR.

AA. Provision Related to Consultant Disclosure Legislation

1. If this contract is for the provision of consulting services as defined in Subdivision 17 of Section 8 of the State Finance Law, the CONTRACTOR shall submit a "State Consultant Services Form B, Contractor's Annual Employment Report" no later than May 15th following the end of each state fiscal year included in this contract term. This report must be submitted to:
 - a. The NYS Department of Health, at the STATE's designated payment office address included in this AGREEMENT; and
 - b. The NYS Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11th Floor, Albany NY 12236 ATTN: Consultant Reporting - or via fax at (518) 474-8030 or (518) 473-8808; and
 - c. The NYS Department of Civil Service, Alfred E. Smith Office Building, Albany NY 12239, ATTN: Consultant Reporting.

BB. Provisions Related to New York State Procurement Lobbying Law

1. The STATE reserves the right to terminate this AGREEMENT in the event it is found that the certification filed by the CONTRACTOR in accordance with New York State Finance Law §139-k was intentionally false or intentionally incomplete. Upon such finding, the STATE may exercise its termination right by providing written notification to the CONTRACTOR in accordance with the written notification terms of this AGREEMENT.

CC. Provisions Related to New York State Information Security Breach and Notification Act

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1. CONTRACTOR shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208). CONTRACTOR shall be liable for the costs associated with such breach if caused by CONTRACTOR'S negligent or willful acts or omissions, or the negligent or willful acts or omissions of CONTRACTOR'S agents, officers, employees or subcontractors.

Appendix H

Federal Health Insurance Portability and Accountability Act ("HIPAA") Business Associate Agreement ("Agreement") Governing Privacy and Security

I. Definitions:

- (a) **Business Associate shall mean the CONTRACTOR.**
- (b) **Covered Program shall mean the STATE.**
- (c) **Other terms used, but not otherwise defined, in this agreement shall have the same meaning as those terms in the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations, including those at 45 CFR Parts 160 and 164.**

II. **Obligations and Activities of the Business Associate:**

- (a) **The Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by this Agreement or as required by law.**
- (b) **The Business Associate agrees to use the appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement and to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any electronic Protected Health Information that it creates receives, maintains or transmits on behalf of the Covered Entity pursuant to this Agreement.**
- (c) **The Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of Protected Health Information by the Business Associate in violation of the requirements of this Agreement.**
- (d) **The Business Associate agrees to report to the Covered Program, any use or disclosure of the Protected Health Information not provided for by this Agreement, as soon as reasonably practicable of which it becomes aware. The Business Associate also agrees to report to the Covered Entity any security incident of which it becomes aware.**
- (e) **The Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by the Business Associate on behalf of the Covered**

Program agrees to the same restrictions and conditions that apply through this Agreement to the Business Associate with respect to such information.

- (f) The Business Associate agrees to provide access, at the request of the Covered Program, and in the time and manner designated by the Covered Program, to Protected Health Information in a Designated Record Set, to the Covered Program or, as directed by the Covered Program, to an Individual in order to meet the requirements under 45 CFR 164.524, if the business associate has protected health information in a designated record set.**
- (g) The Business Associate agrees to make any amendment(s) to Protected Health Information in a designated record set that the Covered Program directs or agrees to pursuant to 45 CFR 164.526 at the request of the Covered Program or an Individual, and in the time and manner designated by Covered Program, if the business associate has protected health information in a designated record set.**
- (h) The Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by the Business Associate on behalf of, the Covered Program available to the Covered Program, or to the Secretary of Health and Human Services, in a time and manner designated by the Covered Program or the Secretary, for purposes of the Secretary determining the Covered Program's compliance with the Privacy Rule.**
- (i) The Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.**
- (j) The Business Associate agrees to provide to the Covered Program or an Individual, in time and manner designated by Covered Program, information collected in accordance with this Agreement, to permit Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.**

III. Permitted Uses and Disclosures by Business Associate

(a) General Use and Disclosure Provisions

Except as otherwise limited in this Agreement, the Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the Covered Program as specified in the Agreement to which this is an addendum, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Program.

(b) Specific Use and Disclosure Provisions:

- (1) Except as otherwise limited in this Agreement, the Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.**
- (2) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the business associate or to carry out its legal responsibilities and to provide Data Aggregation services to Covered Program as permitted by 45 CFR 164.504(e)(2)(i)(B). Data Aggregation includes the combining of protected information created or received by a business associate through its activities under this contract with other information gained from other sources.**
- (3) The Business Associate may use Protected Health Information to report violations of law to appropriate federal and State authorities, consistent with 45 CFR '164.502(j)(1).**

IV. Obligations of Covered Program

Provisions for the Covered Program To Inform the Business Associate of Privacy Practices and Restrictions

- (a) The Covered Program shall notify the Business Associate of any limitation(s) in its notice of privacy practices of the Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect the Business Associate's use or disclosure of Protected Health Information.**
- (b) The Covered Program shall notify the Business Associate of any changes in, or revocation of, permission by the Individual to use or disclose Protected Health Information, to the extent that such changes may affect the Business Associate's use or disclosure of Protected Health Information.**
- (c) The Covered Program shall notify the Business Associate of any restriction to the use or disclosure of Protected Health Information that the Covered Program has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of Protected Health Information.**

V. **Permissible Requests by Covered Program**

The Covered Program shall not request the Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Program, except if the Business Associate will use or disclose protected health information for, and the contract includes provisions for, data aggregation or management and administrative activities of Business Associate.

VI. **Term and Termination**

- (a) *Term.* The Term of this Agreement shall be effective during the dates noted on page one of this agreement, after which time all of the Protected Health Information provided by Covered Program to Business Associate, or created or received by Business Associate on behalf of Covered Program, shall be destroyed or returned to Covered Program, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in The Agreement.
- (b) *Termination for Cause.* Upon the Covered Program's knowledge of a material breach by Business Associate, Covered Program may provide an opportunity for the Business Associate to cure the breach and end the violation or may terminate this Agreement and the master Agreement if the Business Associate does not cure the breach and end the violation within the time specified by Covered Program, or the Covered Program may immediately terminate this Agreement and the master Agreement if the Business Associate has breached a material term of this Agreement and cure is not possible.
- (c) *Effect of Termination.*
- (1) Except as provided in paragraph (c)(2) below, upon termination of this Agreement, for any reason, the Business Associate shall return or destroy all Protected Health Information received from the Covered Program, or created or received by the Business Associate on behalf of the Covered Program. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of the Business Associate. The Business Associate shall retain no copies of the Protected Health Information.
- (2) In the event that the Business Associate determines that returning or destroying the Protected Health Information is infeasible, the Business Associate shall provide to the Covered Program notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, the Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that

make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

VII. Violations

- (a) **It is further agreed that any violation of this agreement may cause irreparable harm to the State, therefore the State may seek any other remedy, including an injunction or specific performance for such harm, without bond, security or necessity of demonstrating actual damages.**
- (b) **The business associate shall indemnify and hold the State harmless against all claims and costs resulting from acts/omissions of the business associate in connection with the business associate's obligations under this agreement.**

Miscellaneous

- (a) ***Regulatory References.* A reference in this Agreement to a section in the HIPAA Privacy Rule means the section as in effect or as amended, and for which compliance is required.**
- (b) ***Amendment.* The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Program to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.**
- (c) ***Survival.* The respective rights and obligations of the Business Associate under Section VI of this Agreement shall survive the termination of this Agreement.**
- (d) ***Interpretation.* Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits the Covered Program to comply with the HIPAA Privacy Rule.**
- (e) **If anything in this agreement conflicts with a provision of any other agreement on this matter, this agreement is controlling.**
- (f) **HIV/AIDS. If HIV/AIDS information is to be disclosed under this agreement, the business associate acknowledges that it has been informed of the confidentiality requirements of Public Health Law Article 27-F.**

ATTACHMENT XVII

Vendor Responsibility Attestation

To comply with the Vendor Responsibility Requirements outlined in Section E, Administrative, 8. Vendor Responsibility Questionnaire, I hereby certify:

Choose one:

- An on-line Vendor Responsibility Questionnaire has been updated or created at OSC's website: <https://portal.osc.state.ny.us> within the last six months.
- A hard copy Vendor Responsibility Questionnaire is included with this proposal/bid and is dated within the last six months.
- A Vendor Responsibility Questionnaire is not required due to an exempt status. Exemptions include governmental entities, public authorities, public colleges and universities, public benefit corporations, and Indian Nations.

Signature of Organization Official: _____

Print/type Name: _____

Title: _____

Organization: _____

Date Signed: _____

ATTACHMENT XVIII

Offeror's List of Required Items

This list is to assist Offerors in submitting a complete Proposal. **Not all RFP requirements are included on this list.** Offerors are responsible for carefully reading the RFP and responding to all requirements. **Failure to provide all required information may result in rejection of the Proposal(s).**

A. Technical Proposal

1. Transmittal Letter - see RFP Section D.1.b.1)
 - a. Offeror contact information
 - b. Conflict of interest information
 - c. Officers/those authorized to negotiate a contract
 - d. Relevant legal/disciplinary actions that may affect Offeror's performance
2. Required Forms – see RFP Sections D.1.b.2)
 - a. Offeror's Assurances – Attachment II
 - b. Offeror's Questionnaire – Attachment III
 - c. Vendor Responsibility Questionnaire – Attachment VI
 - d. NYS Taxation and Finance Form ST-220-CA – Attachment XI
 - e. Vendor Responsibility Attestation – Attachment XVII
3. Subcontractor Information, as applicable – see RFP Section D.1.b.3)
 - a. Subcontractor(s) information
 - b. Responsible officers
 - c. Financial interests
 - d. Willingness to participate
 - e. Relevant legal/disciplinary actions that may affect subcontractor performance
 - f. Vendor Responsibility Questionnaire, as applicable
4. New York State Contracts – See RFP Section D.1.b.4)
 - a. State agency
 - b. Contact and contact's telephone number
 - c. Project budget/time frame
 - d. Description of project
5. Vendor Responsibility documentation – see RFP Section E.8.
 - a. Proof of financial stability
 - b. Department of State registration
 - c. Certificate of Incorporation or other

B. Cost Proposal

1. Transmittal Letter – see RFP Section D.1.c.1)
 - a. Signature of authorized individual
 - b. Assurance of validity of Proposal for at least 270 days
2. Cost Proposal (Attachment VII) – see RFP Section D.1.c.2)
3. Required Forms – see RFP Section D.1.c.3)
 - a. Bid Form (Attachment IV)
 - b. State Consultant Services Form A (Attachment VIII)