

NEW YORK STATE DEPARTMENT OF HEALTH

Request for Proposals for

Office of Health Insurance Programs Division of Financial Planning and Policy

RFP No. 0801031003

Chronic Illness Demonstration Projects

Schedule of Key Events

Proposal Release Date	February 4, 2008
Pre-bid Written Questions	February 19, 2008
Registration for Bidders Conference	February 22, 2008
Bidders Conference	February 26, 2008
Final Date for Submission of Questions	March 17, 2008
Response to Written Questions and Questions Received at Bidders Conference	March 24, 2008
Proposal Due Date	April 14, 2008

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- Submission of Written Questions:
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- Debriefings:
- Negotiation of Contract Terms after Award:

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FOR FURTHER INFORMATION REGARDING THESE STATUTORY PROVISIONS, SEE THE LOBBYING STATUTE SUMMARY IN SECTION I, 10 OF THIS SOLICITATION.

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A. INTRODUCTION

In State Fiscal Year 2007-08, the New York State Commissioner of Health, in consultation with the Commissioners of the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services, was authorized to develop chronic illness demonstration projects (CIDP) to improve health outcomes and reduce costs for persons with chronic medical and behavioral illnesses. The demonstrations will be geographically diverse targeting medically or behaviorally complex Medicaid fee-for-service (FFS) beneficiaries across the State. The specific objective of the program is to improve the health outcomes of individuals who are exempt or excluded from mandatory managed care. (CIDP Legislation, **Attachment 1**)

The New York State Department of Health (DOH) is issuing this request for proposals (RFP) for CIDPs to providers to demonstrate innovative and replicable approaches to address the complex health needs and social barriers to care for this chronically ill Medicaid population. It is anticipated that these innovative demonstrations will result in improved health outcomes, appropriate utilization of health care services and a more cost-effective use of Medicaid funds.

The overarching vision for these demonstrations is to establish innovative, quality-driven interdisciplinary models of care designed to improve health care quality, affordability, and improve clinical outcomes for Medicaid beneficiaries with medically complex conditions. In support of this vision, model programs should promote collaborative, patient-centered, effective and efficient care, utilizing an integrated health care system and care coordination provided by a multi-disciplinary team. Care coordination should serve as a catalyst to assure quality, cost-effective care by linking the patient, medical, mental health and chemical dependence treatment providers, other members of the multi-disciplinary team, and community supports. Interactions with the patients and their caregivers should be frequent and include face to face interventions. In addition, DOH anticipates that selected contractors will utilize existing or will develop new health information technology capacity to enhance program communication, and care management functions of the demonstration.

B. BACKGROUND

The New York State Medicaid program serves over 4 million beneficiaries at a cost of over 47 billion dollars annually. A small portion of Medicaid beneficiaries (20%) account for a significant amount (75%) of the program's expenditures; these beneficiaries have multiple co-morbidities, are medically complicated and require services across multiple provider agencies. Due to their multiple and intensive needs, their care can often be fragmented, uncoordinated and at times duplicative. Included in these special populations are recipients with chronic conditions¹, mental illness, chemical dependency, HIV/AIDS, developmental disabilities and mental retardation, and individuals requiring long term care. There is significant overlap between these special populations. Previous analysis has determined that 40% of these beneficiaries are diagnosed with mental illness and chemical dependency; of which one third of those beneficiaries also have chronic care conditions, HIV/AIDS and are in receipt of long term care.

Medicaid beneficiaries who are exempt or excluded from managed care often remain in Medicaid FFS because they have a complex medical or social circumstance. As such, they generally do not receive coordinated care across their multiple medical, mental health and substance use treatment needs. Fragmented, inappropriate and duplicative care is potentially harmful to patients and increases costs for the Medicaid program. Analysis of Medicaid claims data shows that many of these patients lack medical homes in which they can receive preventive screening and early interventive care. These beneficiaries typically present in emergency departments requiring inpatient hospital admissions with

¹ Chronic conditions include acute cardiovascular disease, acute myocardial infarction, asthma, congestive heart failure, chronic renal failure, congestive pulmonary disease, coronary atherosclerosis, diabetes, hypertension, and sickle cell anemia.

acute conditions, which might have been avoided if routine preventive care had been provided in primary care settings. This lack of preventive care, access to specialty care, and care coordination often results in multiple hospitalizations for chronic conditions (medical, substance use disorders and mental illness) that could have been avoided if appropriately managed in the ambulatory setting. These deficiencies result in costly inappropriate utilization of health care services and poor health outcomes for these recipients.

The current health care delivery system does not assure adequate coordination of the physical-behavioral-social service needs of this population due to their multiple complex health needs. Individuals who have mental illness and/or chemical dependency generally also have chronic conditions. While many receive care for their mental health and/or substance use disorder from the Office of Mental Health (OMH) and/or Office of Alcoholism and Substance Abuse Services (OASAS) providers there are others who are not known to these treatment systems and lack coordinated care for their mental health and/or chemical dependency. In addition, OMH and OASAS providers are not typically staffed to provide general health counseling or health screening, nor are they able to systematically share information with medical and other specialty providers treating the same patients.² Conversely, health care providers may not identify that a patient receiving care for other chronic health conditions would benefit from treatment provided by OASAS or OMH licensed treatment providers. This lack of communication and coordination between medical chemical dependence and mental health providers results in poor outcomes for these medically complex individuals and higher than necessary Medicaid expenditures.

In addition, numerous social barriers to care exist for these complex populations particularly for those with co-occurring mental illness and chemical dependency, especially, the lack of permanent housing. Persons who lack appropriate shelter are often disaffiliated with the health care delivery system especially primary care services. As a result they often experience further deterioration of their physical health and ability to self manage their chronic illness.³ These beneficiaries also generally lack a family/personal support system, may not be health literate, may not understand the complexities of their chronic conditions, or lack the knowledge and resources required to navigate the health care delivery system to obtain care.

1. Beneficiary Eligibility

The demonstrations are for adult, medically complicated Medicaid FFS beneficiaries that are exempt or excluded from managed care. These beneficiaries typically receive their care across multiple delivery systems licensed by multiple agencies. Medicaid beneficiaries will be **excluded** from the demonstration if they are:

- Children under age 18
- Dually eligible for Medicare and Medicaid
- Enrolled in a Medicaid Managed Care plan, Managed Long Term Care plan, Family Health Plus, Special Needs Plan, Assertive Community Treatment Program (ACT), Managed Addiction Treatment Services Program (MATS)
- Residing in a State-operated psychiatric center or free standing psychiatric hospital, Intermediate Care Facility, Skilled Nursing Facility, or hospice
- In receipt of the following Medicaid Home and Community Based (HCBS) Waivers:
 - Long Term Care Home Health Care Program Waiver
 - Traumatic Brain Injury HCBS Waiver

² Horvitz-Lennon M, AM Kibourne, and HA Pincus. 2006. From silos to bridges: Meeting the general health cares needs of adults with severe mental illness. *Health Affairs* 25(3):659-669.

³ U.S. Department Health and Human Services, Substances Abuse and Mental Health Services Administration's Co-Occurring Center for Excellence 2007. Addressing co-occurring disorders in non-traditional service settings. COCE- Over View Papers.

- OMRDD HCBS Waiver
- No longer a Medicaid FFS Beneficiary

Individuals enrolled in Comprehensive Medicaid Case Management (CMCM) may be included in the demonstration project. However, bidders must clearly show how their proposed project will build upon the CMCM's efforts to achieve the goals of this demonstration project. An important component of the CIDP is cost savings. Accordingly, bidders should also be aware that the costs of the CMCM will be included in the determination of cost and cost saving arrangements described below.

Beneficiaries in the Restricted Recipient Program are eligible for participation in the demonstration project.

Eligible patients for the demonstration project will be identified by DOH using a case-finding algorithm that has been demonstrated to be predictive of increased utilization of health and related services that is described below. In general, these patients have limited primary medical care or other outpatient care for their co-morbid mental health or substance use disorder and are at significant risk for a hospital admission in the next 12 months. Upon award, DOH will match eligible patients with the successful bidders based on their prior utilization and geographic proximity. (See below, **4. Geographic Region and Catchment Area Requirements and Attachment 2**)

DOH expects to maintain a highly collaborative and coordinated working relationship with the funded CIDP programs. DOH understands the challenges associated with improving the health of, and containing costs for these high risk patients and will seek to work closely with funded entities to assure the success of these programs.

2. Conditions of Beneficiary Participation

Enrollment and participation in a CIDP will be voluntary. Patients enrolled in a Chronic Illness Demonstration Project will be exempt from enrollment in a managed care plan. Demonstrations may not limit or impair a beneficiary's access to Medicaid services to which a beneficiary is entitled. Beneficiaries must provide their written consent to participate in the demonstration. DOH will provide a required consent form for beneficiary participation in the demonstration project. The DOH approved consent will include mandated language on the sharing of medical, mental health and chemical dependence treatment information that will enable DOH to share a full claims history and current utilization with the demonstration providers. Selected contractors may propose changes to the consent form, but all consent forms must be approved by the DOH.

3. Target Population and Geographic Regions

In defining the targeted patient group an examination of five years of Medicaid FFS claims data (2002-2006) was conducted. For patients with any inpatient admission in the fourth year of data, information from the prior 3 years of records was examined. Using logistic regression techniques, a case-finding algorithm produced a risk score to predict patients at high risk for re-hospitalization (medical, mental illness, substance use, or surgical) in the following twelve months. The risk prediction algorithm includes variables on prior hospital admissions, emergency department visits, outpatient utilization/claims, pharmacy and durable medical equipment (DME) use, diagnostic information from inpatient and outpatient claims, and patient characteristics including age, gender, and race/ethnicity.

Using the DOH predictive modeling case-finding algorithm, a representative population for care coordination was prepared to assist bidders in proposal development. The risk stratified population identified includes high cost, high risk Medicaid FFS recipients, age 18 and over with risk scores of 50+. In this context, risk is defined as patients who are anticipated to have a hospital admission within the upcoming year. Statewide, 67% of patients identified by the case-finding algorithm will have a non-

injury, non-obstetrical admission in the next year, with the average of 2.4 admissions for all patients identified.⁴

The majority of these medically complex beneficiaries are diagnosed with mental health and/or chemical dependency and have at least one chronic medical condition, with a majority having multiple chronic conditions. Chronic conditions of high incidence include asthma, diabetes, HIV/AIDS, hypertension, bipolar disorder, and schizophrenia.

It should be noted that the data for assigning these risk scores is based on Medicaid claims data and the level of severity of individual conditions cannot be predicted. However, these data do document for large numbers of these patients a lack of primary care, the absence of a medical home, high use of emergency room and frequent hospitalizations.

Included in **Attachment 2** are a series of tables that provide demographic characteristics cost of care and inpatient diagnosis detail for the risk scored population.

- **Tables 1 & 2**, Statewide and NYC Demographic Characteristics for Patients with Risk Scores of 50+ by Metro Service Area or Borough; including beneficiary number, average age, sex and race breakout by percentage.
- **Tables 3 & 4**, Statewide and NYC Prior Diagnostic History of Patients with Risk Score 50+, by Metro Service Area or Borough; including medical, mental illness, substance use.
- **Tables 5 & 6**, Non-NYC and NYC Patients with Risk Score of 50+, Detailed Diagnostic History by Percentage of Co-Occurring Conditions.
- **Tables 7 & 8**, Statewide and NYC Average Medicaid Expenditures for Patients with Risk Score of 50+ for the Prior 12 Months to Index Admission, by Category of Service, i.e. inpatient, emergency department, primary care visits, specialty and psychiatric care, etc. by Metro Service Area or Borough.
- **Tables 9 & 10**, Statewide and NYC Utilization of Services for Patients with Risk Score of 50+ for Prior 12 Months to Index Admission by Percentage of Category of Service by Metro Service Area or Borough.

4. Geographic Region and Catchment Area Requirements

A series of tables have been developed using the case-finding algorithm to assist bidders to determine patient count and potential network members for their proposed CIDP. These tables are also included in **Attachment 2**. The tables include a list of hospitals and institutional ambulatory services providers “touched” (obtained services) by patients with a risk score of 50 or greater in the 12 months prior to the index admission. Even though, DOH is only providing a list of hospital and institutional ambulatory care providers, bidders should also include other types of providers in their network that are pivotal in providing the physical, behavioral and social needs of this complex population.

Please note these counts **do not** represent unduplicated patient counts for hospitals and/or provider visits. Demonstrations must have an average minimum monthly enrollment of **500** enrollees and can have an average maximum monthly enrollment of **550** enrollees. Therefore, DOH recommends a patient count of at least **700** be derived from a combination of both hospital(s) and provider(s) counts to meet the DOH enrollment minimum. The bidder must be able to demonstrate the capacity to enroll and serve sufficient number of enrollees to demonstrate the cost effectiveness of the demonstration.

DOH is seeking demonstrations that are geographically diverse and represent both Upstate and Downstate New York. Using the case-finding algorithm DOH has developed CIDP Regions within the Upstate and Downstate Regions (**Attachment 3**). Bidders will be asked to identify the Geographic

⁴ For further information on the how the algorithm is developed, see Billings J, Mijanovich T, “Improving Management of Care for High-Cost Medicaid Patients”, Health Affairs: no 6 (November/December) 1643-1655.

(Upstate or Downstate) and CIDP Region and the specific catchment area by county and zip codes in which the demonstration will be conducted. The bidder must also provide the number of enrollees that will be served by the demonstration.

Upon award, DOH will work with each CIDP to develop more detailed descriptive information on the patients meeting these specifications, including information on their most recent utilization history to assist the CIDP in planning. At the commencement of the demonstrations, utilizing the predictive modeling risk algorithm DOH will provide each CIDP a target population eligible for enrollment located within the catchment area of the network of the contractor and meeting the conditions or prior linkage. On a regular basis during program operations each demonstration will be provided additional eligible candidates for enrollment.

5. Start Up Period and Work Plan

Bidders will be required to submit a proposed work plan and schedule of deliverables for completion of all contract activities which includes a detailed timeline for start up as part of their bid. The start up timeline should reflect the ability to complete all preparation and start up activities within three (3) months of commencement of the contract. A final work plan and schedule of deliverables will be due to DOH 2 weeks after the contract is executed. The final work plan and schedule of deliverables is subject to DOH approval.

The demonstration operation and enrollment period will commence effective month four (4) of the first contract year.

C. DETAILED SPECIFICATIONS

1. Scope of Work

DOH is seeking demonstration projects that will propose comprehensive care management strategies for the targeted patient group. Bidders are expected to define care coordination models that include an integrated health care delivery network, including community providers, which ensure beneficiaries appropriate access to the continuum of medical, mental health, chemical dependence, rehabilitative care and social services required to meet the complex needs of this population.

- A. The demonstrations will be responsible to provide care coordination for high need, high cost beneficiaries with multi-faceted interventions that include at a minimum core elements, including:
 - 1) Comprehensive health assessments that identify medical, mental health, chemical dependence treatment and social service needs;
 - 2) Individualized patient-centered care plans to address those needs with periodic reassessments;
 - 3) Integration of medical, mental health, chemical dependence and social service needs in care planning and coordination activities;
 - 4) Care coordination to ensure access to all needed services, including referral for services and follow up;
 - 5) Provider engagement strategies to assure these disenfranchised patients are appropriately served;
 - 6) Patient self-management/activation interventions to improve patients' motivation to achieve health goals and education to enhance their independent use of the health care delivery system; and
 - 7) Caregiver/Family support/involvement.

- B. The CIDPs will strive to achieve and maintain optimal enrollee health status over the care continuum by effectively providing, integrating, coordinating, monitoring and evaluating healthcare

services for purposes of meeting individual patients' needs, and for promoting quality and cost-effective outcomes.⁵ DOH is seeking care coordination models that:

- 1) Provide integrated systems of care, including treatment for medical, mental health, substance use treatment disorders and social services;
- 2) Utilizes a multi-disciplinary team approach;
- 3) Are patient-centered and culturally competent and sensitive;
- 4) Support patient engagement in their health and improve their self management skills;
- 5) Support patient engagement and on going retention to care;
- 6) Support a medical home and development of treatment relationships with primary care providers;
- 7) Facilitate recipient navigation of the health care system;
- 8) Utilize health information technology applications;
- 9) Have data transfer capability;
- 10) Promote and encourage providers to follow best practices or evidence-based standards of care;
- 11) Improve coordination of primary, acute, specialty, behavioral and long-term care;
- 12) Utilize principles of continuous quality improvement; and
- 13) Improve health outcomes, and decrease utilization of inappropriate health care services thereby reducing Medicaid expenditures.

2. Eligible Bidders

Eligible bidders who may apply to conduct a Chronic Illness Demonstration Project include: hospitals, diagnostic and treatment centers, nursing homes, certified home health agencies, licensed homecare service agencies, long term home health care programs, managed care plans, and providers licensed or funded by the Office of Mental Health or the Office of Alcoholism and Substance Abuse Services. All bidders must have New York State licensure and/or certification.

3. Integrated Health Care System and Community Provider Network

DOH seeks CIDP models that involve an "integrated health care system and community provider network" that ensures coordinated care and service delivery across the continuum of medical, mental health, rehabilitative care and social services required by high cost, high risk patients with complex needs. An integrated health care system and community provider network must have the following characteristics:

- A. Enhanced capacity for provision and management of community based medical and social care for participating beneficiaries, including:
 - 1) Multi-disciplinary needs assessment and care coordination;
 - 2) Inclusion of DOH, OMH and OASAS licensed providers;
 - 3) Extended/convenient hours, optimally same-day appointments for ambulatory care services;
 - 4) Coordination of care and services post critical events, such as emergency department use, hospital inpatient admission and discharge;
 - 5) Language access/translation capability;
 - 6) 24 hour 7 days a week telephone access to a care manager;
 - 7) Community outreach and monitoring; and
 - 8) Community based social support services.
- B. Enhanced information technology capabilities among participating health and social service providers that permit:
 - 1) Tracking/sharing utilization and care needs information across providers;

⁵ Kastebs. J. 1998. Integrated care management: aligning medical call centers and nurse triage services. Definition of Integrated Care Management developed by KR Associates. Nursing Economics.

- 2) Coordination of referrals and documentation of acquisition of services;
- 3) Notification of care coordinators of critical events, such as hospital admission or emergency department use; and
- 4) Provider performance monitoring and feedback.

While electronic health records (with registries, decision support, tracking and reminders on evidence-based care standards, etc.) that permit sharing clinical and utilization information among participating health providers may not be in place at the time of an award, an effective “integrated health care system” would be expected to have a plan for achieving such capacity.

- C. A formal arrangement among participating system and network providers representing all categories of service for which beneficiaries are eligible that defines the terms of participation and responsibilities of each provider, including how contract funds will be distributed, how any financial risks or shared savings will be allocated, and how the “integrated health care system and community provider network” will be governed.

4. Reporting Requirements

Contractors will be required to submit reports and data which will be used by the DOH to assess whether the contractor is meeting program objectives, timeframes and performance standards. The format and content of all reports must be approved by DOH and are subject to revision during the contract period. At a minimum the contractor will be required to provide a report quarterly, annually and on a final basis.

A. Quarterly Reports, minimum reporting requirements

- 1) By Medicaid Client Identification Number (CIN), using MS Excel or Access (or other table or series of tables), for each intervention enrollee record provide the following data:
 - a. Indicator of current enrollment status of intervention enrollee, who:
 - Has been contacted and enrolled,
 - Declined enrollment
 - Disenrolled and reason for disenrollment
 - Not yet contacted.
 - b. Program activities
 - Total number of interventions completed, by type with, or on behalf of the enrollee
 - Initial & ongoing health assessment, with date completed
 - Initial & ongoing patient perception survey, with date completed and score
 - Indicator of established medical home, with date established
 - Indicator of established care plan, with date established and revised

- 2) Progress Report- a brief narrative providing the status of all CIDP program functions and activities.

Quarterly reports are due the Department no later than thirty (30) calendar days following the close of the reporting period.

B. Annual/Final Reports

- 1) A summary report of all program activities and outcomes.

Annual reports are due to the Department no later than sixty (60) calendar days following the close of the reporting period.

5. Data Exchange Application

The selected contractor will be required to complete, and have approved, a New York State Data Exchange Application and Agreement (DEAA) prior to being allowed access to Medicaid confidential data. Bidders may request an electronic copy of the DEAA for review.

D. PERFORMANCE STANDARDS

Awarded entities will be evaluated on the following measures of performance:

1. Patient Assessments

DOH anticipates the health assessment will incorporate the full scope of the enrollee's physical and behavioral health and social service needs, including, but not be limited to, the following core elements (areas): demographic information; diagnoses and health related services; mental health and substance use; activities of daily living; informal supports; health goals; communication, cognition and patient self perception of health. The assessment will be submitted to DOH for review and approval. The assessment will also be expected to include a limited set of standardized questions across all CIDPs (e.g., SF-8) for tracking patient's perception of their health status and their engagement and satisfaction with the health care delivery system. CIDPs will be required to report to DOH individual enrollee's scores for the health perception questionnaire on an initial and ongoing basis. (See Section C. 4) Health assessments will be conducted on an initial, semi-annual basis or after a trigger event that results in a change in the enrollee's health status. The health assessment and reassessment will be utilized as the basis for development and maintenance of an individualized care plan that will address the goals and needs of the patient over the course of CIDP enrollment. The health assessment must be completed within 30 days of enrollment.

2. Health Care Service Utilization Measurement

The DOH will utilize a pre-post Medicaid service utilization claims analysis of individual intervention enrollees compared to similarly risk scored patients in the control group for determining the risk withhold payment of the monthly care coordination fee. A similar analysis will be done on the aggregate intervention group compared to the control group to determine shared cost savings. Additionally, DOH will analyze intervention enrollees service utilization patterns, such as, but not limited to: inpatient hospital admissions, emergency department use, primary care provider/clinic and outpatient mental health and substance use treatment services, and prescriptions filled as measure of treatment adherence.

E. PROGRAM EVALUATION

The CIDPs will be closely evaluated to assess the impact of the interventions on participants' patterns of care, costs, and health outcomes. The evaluation design will use the most rigorous possible method, with the preference being for random assignment of the identified target population into intervention and usual care (control) groups.

The effect of the intervention will be based on an analysis of the difference in outcomes between the group receiving the intervention and the group receiving usual care. If the number of patients with risk scores of 50+ who meet the CIDP's specifications (catchment area, and specific "touch" criteria to be determined at a later date) is sufficient, patients will be randomized by DOH with half of eligible patients assigned to the CIDP for enrollment and half withheld for inclusion in the control group.

DOH estimates that a minimum CIDP average monthly enrollment of **500** patients will be required in the intervention group to demonstrate scalability and to provide adequate sample size for the evaluation. The DOH maximum average monthly enrollment for a CIDP is **550** enrollees.

If during the course of the demonstration, a CIDP exhausts the intervention group of potential enrollees without meeting the minimum average monthly enrollment requirement of 500 enrollees, the DOH will release the control group for enrollment in the CIDP. A second control group of similarly risk scored patients will then be established, meeting the CIDP's specifications in another geographic area. This second control group will be used for risk and shared savings analysis.

The evaluation will also determine the CIDP's cost-effectiveness and may be conducted by either DOH or a third party evaluator. Findings and recommendations whether to extend, modify, eliminate or make permanent CIDP program(s) will be reported to the Governor and Legislature no later than January 1, 2010.

F. CONTRACTOR PAYMENT

DOH is authorized to spend \$10 million in state funds the first contract year and is expected to spend annually for three years for demonstrations targeting high need, high cost Medicaid FFS beneficiaries that are medically complicated. It is anticipated that federal matching funds will be available for a significant percent of these State funds.

The maximum award for a CIDP program will be one million seven hundred and fifty thousand dollars (\$1,750,000), per contract year or a total of five million two hundred and fifty thousand dollars (\$5,250,000) for the thirty-six month contract. **Any bidder that submits a proposal that exceeds the maximum award will be disqualified.**

CIDP bidders will propose a monthly fee for the provision of care management services to enrolled beneficiaries. All other Medicaid services will remain available for reimbursement via routine claims processing. CIDP contractors will be paid on a monthly basis for those beneficiaries that are actively enrolled and have met the threshold of one face to face or two other intervention types with each individual enrollee each month. At least one face to face intervention with individual enrollees will be required each quarter. (See Section H)

1. Start Up and Enrollment Costs

Start up and enrollment costs are each one time expenses and are limited to the first three (3) months of contract year 1. Demonstration operations and active beneficiary enrollment will commence effective month four (4) of contract year 1, or upon successful completion of start up and enrollment deliverables.

Start up costs may total no more than ten (10) percent of the approved operations cost for 12 months of operations. This cost will be based upon the bidder's proposed monthly enrollment target times the monthly care coordination fee for this period.

Enrollment costs may total no more than fifteen (15) percent of the approved operations cost for 12 months of operations. This cost will be based upon the bidder's proposed targeted average monthly enrollment times the monthly care coordination fee for this period. It will be at DOH's discretion to recover enrollment costs from CIDP programs that do not meet fifty (50) percent of their enrollment target by the end of contract year 1.

Start up costs may include initial staffing and project-related technology expenses. No capital construction or renovation expenses are permissible under this agreement. Enrollment costs may include staff for outreach and materials promoting the program.

Start up costs and per beneficiary per month care coordination expenses will be funded with up to \$7 million in funds dedicated to this purpose. The NYS DOH will make available an additional \$3 million for quality and cost savings incentive payments. However, with the availability of federal financial participation these funds are expected to increase to an amount of approximately \$20 million (\$14M for care coordination and \$6M for quality/cost savings incentives).

2. Monthly Care Coordination Fee

DOH will reimburse the contractors a monthly care coordination fee (MCCF). There will be **no** withhold of this monthly fee, however thirty (30) percent of the MCCF will be placed at risk against quality and cost standards. One-third (33.3%) of **at risk** MCCF funds will be linked to quality reporting and

performance, with the two-thirds (66.6%) balance of **at risk** MCCF funds associated with cost savings standards.

Contractors are at risk on a per beneficiary basis should targeted savings in expenditures not be achieved. If a recoupment of **at risk** MCCF funds are necessary these funds will be withheld from the amount due the contractor or Medicaid claims payment from the lead agency. The allocation of shared savings is described below.

3. Quality Reporting and Performance Requirements

Within three months of a beneficiary's enrollment, contractors must provide documentation of completed initial health assessments and updated individualized service plans. Each month provider must have conducted a face to face or two other types of interventions with every enrollee. Patient interventions types and number must be provided on a quarterly basis. (See Section H)

Contractors that cannot produce these documents for ninety-five percent (**95%**) of enrolled patients will refund the DOH one-third (33.3%) of the **at risk** MCCF funds for quality and performance reporting for contract years 2 and 3. However, it will be at DOH's discretion to recoup **at risk** MCCF funds for quality and performance reporting at the end of contract year 1.

Contractors must meet quality performance and reporting standards to be eligible to share in aggregate cost savings (see below).

4. Cost Reduction Targets and Risk Arrangements / Shared Savings

It is expected that demonstrations will realize savings at least equal to the MCCF paid to the demonstration as compared to a control group. (See Section E Program Evaluation for a more detailed description of the control group) Demonstrations that do not meet this expectation will be at risk for a portion of their MCCF and those that exceed this expectation will share in savings as described below.

Program cost reduction targets will be applied and assessed on a per patient basis with regard to **risk arrangements** and on a total member basis for **shared savings** (see below).

5. Risk Arrangement

Contractors are at risk for 20% the MCCF (66.6% of at risk funds) for each **individual patient** whose annual care expenses – including the MCCF – exceed the average cost of all similarly risk scored patients in the control group. Contractors **will not** be at risk for annual care expenses and the MCCF for contract year 1, which includes the implementation period (months 1 – 3) and the first 9 months of operations (months 4-12). Contractors **will be** at risk for annual care expenses and the MCCF for contract years 2 and 3. Risk will be measured for both contract years 2 and 3, starting Day 1 though Day 365 respectively of each year. As noted above, beneficiaries who are eligible for the CIDP have been identified via a case-finding algorithm and have been assigned a risk score of 50 or greater (i.e. 57, 76, 83, etc).

6. Shared Savings

Contractors are eligible to participate in shared savings, if they meet the quality reporting requirements above, and have annual **aggregate** expenses that are below eight five (85) percent of the expenditures of the control group including the annual aggregate MCCF expense for their enrolled beneficiaries. Contractors **will not** be able to participate in shared savings for contract year 1, which includes the implementation period (months 1 – 3) and the first 9 months of operations (months 4-12). Contractors **will be** able to participate in shared savings for contract years 2 and 3. Shared savings will be measured for both contract years 2 and 3, starting Day 1 though Day 365 respectively for each contract year. Savings will be reimbursed up to fifty (50) percent the extent funds are available in the \$3 million pool (or \$6 million with federal matching funds).

Shared saving calculations will be based on the following, but not limited to: a lagged claims set; excluding trauma and obstetrical claims (as defined by ICD 9-CM diagnosis codes), and excluding Medicaid expenditures outliers (to be defined after reviewing distribution of expenditure data)

In the case where total costs savings for all demonstration projects exceeds the total available funds in the pool, reimbursements will be weighted by the percent of total savings for each CIDP. For example, if there are three funded CIDPs, Project A, B and C, and Project A is entitled to \$1 million in shared savings, Project B is entitled to \$1.25 million in shared savings and Project C is entitled to \$1.5 million in shared savings – for a total of \$3.75million. Each project will receive funds equivalent to their percent of the total saved funds. In this example, Project A will receive 27% of the pool, Project B will receive 33% and Project C will receive 40%.

7. Prime Contractor

DOH will contract with the lead agency in proposals to this RFP as the prime contractor. The prime contractor is solely responsible for meeting all provisions of the contract. The prime contractor will receive payment from the DOH for start up and enrollment costs and for the administration of the care coordination function via the monthly care coordination fee (MCCF) for actively enrolled beneficiaries. The prime contractor will solely be responsible for all risk / shared savings provisions of the contract.

Bidders should understand that while DOH seeks CIDP’s that include an integrated health system and community provider network of medical, behavioral and social services providers, arrangement with entities/subcontractors working for the prime contractor, or as an integrated health system/network participant for allocation of CIDP funds and distribution of risk / shared savings with these entities does not alter the contractual or fiscal responsibility of the prime contractor to the State.

G. PROCUREMENT TIMELINE

The following is a timeline for the request for proposal process and demonstration project development.

ACTION	DATE
Pre-bid Questions	February 19, 2008
Registration for Bidders Conference	February 22, 2008
Bidders Conference	February 26, 2008
Letter of Interest	March 3, 2008
Final Date for Submission of Questions	March 17, 2008
Response to Written Questions and Questions Received at the Bidders Conference	March 24, 2008
Proposal Due Date	April 14, 2008
Bidder Selection Announced	June 16, 2008
Demonstrations Begin	October 1, 2008
Demonstrations End	September 30, 2011

H. PROPOSAL REQUIREMENTS

The requirements established by this RFP for proposal content and format will be used to evaluate proposals. The bidder’s compliance to the format prescribed herein, as well as the bidder’s response to each specific requirement and question stated in the RFP, will be considered during the evaluation process. The bidder’s technical or cost proposals shall not be conditioned and/or contingent.

Proposals should provide a concise but complete description of the bidder’s ability to meet the requirements of the RFP. Proposals must be submitted, on paper, in two distinct parts, **Part 1 –**

Technical Proposal, and Part 2 – Financial Proposal, separately sealed and identified with the name of the bidder and RFP # 0801031003.

No cost or pricing information should be submitted in a bidder’s Technical Proposal.

Each page of the proposal should be numbered consecutively from the beginning of the proposal through all appended material. Narrative should be double spaced, using a 12 pitch font or larger, with minimum 1 inch margins all around, and adhere to the maximum page limits.

1. TECHNICAL PROPOSAL

Responses to all proposal requirements must be addressed in the Technical Proposal.

The Technical Proposal consists of a narrative description of how the bidder will manage all aspects of the demonstrations as described in **Section C- Detailed Specifications** of this RFP and as outlined below. Bidders may provide additional information or recommendations relevant for consideration in the State’s determination of award of this contract. Each bidder’s Technical Proposal should include separate responses to the following requirements pertaining to substance and general content:

1) Letter of Transmittal

The bidder’s Technical Proposal must contain a Letter of Transmittal signed by an official of the lead bidder authorized to bind the bidder to the provisions contained therein. The letter should include:

- a. A statement designating the name of the organization that will contract with the NYSDOH.
- b. Include the name, title, address and phone number of the representative whom DOH staff may contact during the review process.
- c. Affirm that the proposal and all provisions of the offer price are to remain in effect for 365 calendar days commencing the due date of the proposal.
- d. The names of all organizations included in the demonstration project; and
- e. A statement attesting to the accuracy and truthfulness of all information contained in the proposal.

2) A cover page with identifying information using the template in **Attachment 4**.

3) Executive Summary (2 page maximum)

- a. Identify the Integrated Health Care and Community Provider Network.
- b. Identify the lead entity in the network and project leader.
- c. Using Attachment 2, provide the number of patients served by the network or facilities proposed.
- c. Identify the primary service provided by each entity in the network.
- d. Briefly describe the proposed care coordination intervention and other unique service offerings.

4) Integrated Health Care System and Community Provider Network (10 page limit)

A. Describe the integrated health system/community network, including:

- a. Name, capacities and relevant experience of each participant in serving the target population.
- b. Roles and responsibilities of each participant.
- c. How the integrated system/network will be governed.
- d. How will access to all needed services be assured for enrollees in the integrated network?
- e. How the integrated system/network meets the characteristics as described in Section C above.

B. For each integrated system/network participant, a memorandum of agreement or a subcontract shall be provided setting out the terms and conditions of the provider’s participation and the responsibilities that the provider has agreed to undertake.

C. Describe how the integrated system/network will operate to meet the health, mental health, chemical dependence and social care needs of these high risk, high cost patients, including

- a. Needs assessment, care plan and intervention development and implementation.
- b. Care and service integration and coordination.

- c. How care coordination and referral for needed services among network participants will be assured and provided for enrollees.
- d. Community social support inclusion.
- e. Other key elements of the intervention.

5). Proposed CIDP Geographic Catchment Area (1 page)

Complete the Technical Proposal Form: CIDP Catchment Area (**Attachment 5**), provide:

- a. CIDP Geographic Region and CIDP Region selected to conduct the demonstration
- b. County(s) and zip codes of beneficiaries residence
- c. Provide the targeted enrollment number for the demonstration (minimum 500, maximum 550 enrollees)

6) Outreach and Enrollment of Eligible Beneficiaries (4 page limit)

Describe how the outreach and enrollment process will be conducted, including

- a. Strategies and communications that will be used to solicit enrollee buy-in to participate and enroll.
- b. Types of outreach, frequency, and number of attempts to reach beneficiaries for enrollment.
- c. Outreach and enrollment staffing, including number, staff composition, experience with the targeted population.
- d. Outreach and enrollment strategies for beneficiaries that are currently known to the facilities in the network, i.e. during a hospitalized, emergency room or clinic visit, or other treatment.
- e. Outreach strategies that will be employed to locate potential enrollees when addresses or telephone numbers prove not to be accurate.
- f. Outreach strategies to locate beneficiaries who are homeless and residing in temporary housing.
- g. Strategies to be used to garner participation from beneficiaries with cognitive or physical disabilities.

7). Enrollee Assessment, Care Plan Development and Interventions (12 page limit)

Describe the following:

- a. Care coordination intervention; include any research or experience to support the efficacy of the proposed model.
- b. Identify the best practices and evidence-based guidelines on which the assessment, care plan and interventions will be based.
- c. Describe how the medical and behavioral health assessment/care plan and intervention protocols maintain consistency with current best practices and evidence-based care.
- d. Describe how the assessment of needs will be conducted for each enrollee, regardless of the disease or condition, to meet the goals and expectations of the CIDP.
- e. Describe how the care plan is developed including how the health assessment findings, co morbid conditions, enrollee and caregiver/family member concerns, and social concerns will be addressed to meet the needs and goals of the enrollee.
- f. Provide a complete description of the care coordination services and interventions that will be utilized.
- g. Frequency, mode and types of enrollee interventions.
- h. How will the effectiveness of care coordination services and intervention activities be measured and evaluated to determine if enrollees are meeting established goals?
- i. Care plan reassessment semi-annually or subsequent to a marked change (trigger event) in physical or behavioral health status or an inpatient admission.
- j. Engagement strategies to retain and assure that patients are active participants in the care plan.
- k. Mechanisms that will be utilized to enhance patient engagement and self management of their chronic conditions.
- l. Mechanisms and strategies that will be utilized to assure enrollee retention to care.

- 8). Demonstration Personnel and Staffing (3 page limit)
- a. Describe the staffing proposed for the CIDP, position description, credentials, licensure, required experience for key personnel and care managers, including lead clinician, lead administrator, lead Information systems manager (this individual is responsible for data and program evaluation submissions)
 - b. Describe patient to staffing ratios.
 - c. Describe provider competence in engaging and delivering appropriate care to disenfranchised patients, especially patients with mental health or chemical dependency histories.
 - d. Provide assurances on cultural and linguistic competency and sensitivity to issues of patient identity including race, ethnicity, sexual orientation and gender identity.
- 9). Quality Assurance and Improvement (2 page limit)
- Describe the bidder's plan and processes for conducting ongoing quality assurance and improvement of all components of the CIDP, including:
- a. Provision of high quality services that result in positive outcomes for the population managed.
 - b. Procedures and metrics that will be used to review and evaluate clinical outcomes, appropriateness of care and enrollee satisfaction.
 - c. Identification of quality issues and opportunities for improvement of interventions.
 - d. Care management staffing initial and ongoing training and quality assurance
- 10). Data Management Systems and Reporting (3 page limit)
- Describe the bidder's status and capacity to:
- a. Utilize Health Information Technology.
 - b. Collect and track data on all demonstration activities.
 - c. Communicate with, track and share data within the integrated health care system and community network.
 - d. Data transfer capability.
 - e. Provide on-line access to DOH to monitor program activities.
 - f. Meet DOH reporting requirements.
- 11). Work Plan (5 page limit)
- Using the template provided in **Attachment 6** provide a detailed work plan for the start up and operational phases of the CIDP.
- a. List specific tasks of the project and estimated time frames for completion of tasks.
 - b. Describe the roles of personnel who will be implementing and conducting the CIDP.

2. FINANCIAL PROPOSAL

All costs should be based on the information included in the RFP. The DOH may choose to pursue matching federal funds or federal financial participation (FFP), or other sources of additional funding, however, such funds will not be included in the financial evaluation process.

The bidder's Financial Proposal must contain a cover sheet (**Attachment 7**) signed by an official authorized to bind the bidder to the provisions. The Financial Proposal Form found in **Attachment 8** must be used to submit the financial proposal.

3. METHOD OF AWARD

During the evaluation process, DOH may require clarifying information from a bidder for the purpose of assuring DOH's full understanding of the bidder's responsiveness to the RFP requirements. This clarifying information must be submitted in writing in accordance with formats set forth in this RFP and, if received by the due date set forth in the DOH request for clarification, will be included as a formal part of the bidder's proposal.

Proposals deemed by DOH to be responsive to the Submission Requirements set forth in this RFP will be evaluated by DOH staff, assisted by other persons as DOH deems appropriate. In order to award a contract, DOH will select the bidder that submits the proposal that offers the best value.

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. Pass/Fail Requirements

All proposals will have an initial pass/fail screening for the following requirements:

1. The bidder is eligible to bid as described in Section C. 2.
2. Network of facilities have served at a minimum 700 patients
3. Demonstration average monthly enrollment of 500 enrollees minimum, 550 enrollees maximum.

2. Technical Proposal Score (80 points)

DOH will evaluate and score proposals based on each bidder's ability to perform the Scope of Work and Detailed Specifications described in this RFP. Any bidder that receives a raw score of sixty (60) or below, will be disqualified and will not be considered for an award.

The evaluation will be based on the bidder's written technical proposal and responses to clarifying questions, if any.

The following formula will be used to determine each bidder's final technical proposal score:

$$t = (x / y) * 80 \text{ where}$$

x = raw technical score of proposal being scored,

y = raw technical score of highest technical scoring proposal,

80 = total technical points available, and

t = normalized technical score for bidder being scored.

The bidder receiving the highest technical score will receive eighty (80) points and the remaining bids will then be normalized against the highest scored proposal received based on the relative ranking of the technical score.

3. Financial Proposal Score (20 points)

The Financial Evaluation Team will evaluate and score each bidder's financial proposal. The proposed price will be reviewed for completeness and consistency with instructions and the Financial Proposal Form requirements provide in the RFP. The bidder's financial score will be determined based on the following formula:

$$c = (a / b) * 20 \text{ where:}$$

a = total cost of lowest cost proposal

b = total cost of proposal being scored

20 = total cost points available

c = normalized financial score for bidder being scored

The following financial evaluation process will be applied:

The total bid price of the CIDP will be used to calculate the bidder's final financial proposal score. The total price is equal to the sum of the start up and enrollment cost and the total operations cost for the total length of the three (3) year CIDP. Only bidders with technical proposals receiving a raw score of sixty (60) or above will be scored.

The total financial proposal score will be normalized based on a maximum score of twenty (20) points. The total financial proposal score will be normalized against the lowest priced CIDP proposal.

4. Total Combined Score and Contractor Selection

To arrive at the Total Combined Score, DOH will combine the bidder's Technical and Financial Scores. The maximum score any bidder can receive is 100 points. The selection committee will select bidders with the highest combined scores, using the following formula:

The normalized technical score plus the normalized financial scores for each bid will be added to provide a total combined score for each bidder.

The selection committee will base their selection of responsible bidders on the highest combined scores. The committee will select proposals consistent with requirements that:

- Utilize an integrated health care system and community provider network which ensure beneficiaries appropriate access to the continuum of medical, mental health, chemical dependence and rehabilitative care and social services
- Proposed sufficient population to support the goals and objectives of the CIDPs.
- Are geographically diverse.

DOH is seeking demonstrations that represent both Upstate and Downstate geographic regions. Each geographic region contains two (2) or more CIDP regions. Awards will be made by geographic and CIDP regions, until funds are exhausted.

Combined scores will be calculated by geographic region. Proposals will be ranked by lowest to highest; by geographic region according to their combined score. There maybe one (1) or more awards in each geographic region. If there is more than one award in the Upstate geographic region, each Upstate CIDP region is limited to one award. If there is more than one award in the Downstate geographic region, the Long Island and Westchester CIDP regions are limited to one (1) award. However, the NYC Metro Area CIDP region may be awarded more than one (1) contract.

If two (2) or more proposals are tied for the highest score and are proposing to conduct a demonstration in the same geographic region the award will be issued to the proposal with the lowest price.

In the event that current legislation and/or the amount of funding available is amended prior to the selection process being completed, the Committee will make its recommendations consistent with the revised legislative guidelines and funding.

The Committee will recommend the selected bidders to the DOH, who will then approve the final selections. If the State is unsuccessful in negotiating a contract with the selected bidders within an acceptable time frame, the State may begin contract negotiations with the next qualified bidders in order to serve and realize the best interests of the State.

Prior to final selections, this RFP and all responses thereto are subject to various State reviews. In addition, the DOH, Attorney General, and the Office of the State Comptroller must approve the final contract.

I. ADMINISTRATIVE INFORMATION

1. ISSUING AGENCY

This Request for Proposals (RFP) is a solicitation issued by the New York State Department of Health. The Department is responsible for the requirements specified herein and for the evaluation of all proposals.

2. INQUIRIES

Any questions of a technical nature concerning this solicitation must be directed to:

Jay Laudato
Assistant Director
Division of Financial Planning and Policy
NYS Department of Health
99 Washington Avenue, Suite 720
Albany, NY 12210

Each question raised should cite the RFP section, paragraph and page number to which it refers. Requests to receive responses to written questions may also be mailed to the address above. **Written questions and requests to receive responses will be accepted until March 17, 2008.**

Prospective bidders should note that all clarifications and exceptions, including those relating to the terms and conditions of the contract, must be raised prior to the submission of a proposal.

a. Letter of Interest

The Letter of Interest must be received by the issuing agency no later than March 3, 2008. The Letters of Interest are not mandatory and does not commit the bidder to submit a proposal. However, only those potential bidders that which have submitted a Letter of Interest will automatically receive written questions and answers relating to the RFP.

b. Bidders Conferences

A non-mandatory Bidders Conference will be held at the, EGG Swyer Theater, Empire State Plaza, Albany, New York, 12242 on February 26, 2008, from 11:00 am to 1:00 pm. Interested bidders should register for this conference by completing and returning the form in **Attachment 9** by February 22, 2008. The registration forms may be returned by mail or faxed at (518) 473-4400.

c. Responses

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 March 24, 2008. Bidders wishing to receive these documents via mail must send a request, in writing, to the Department at the address above.

d. Notification of Award

A proposal award notification letter will be sent to successful bidders indicating a conditional award subject to successful contract negotiations. The remaining bidders will be notified of the conditional award and the possibility that failed negotiations could result in an alternative award.

3. SUBMISSION OF PROPOSAL

Interested bidders should submit two **original and eight (8) signed copies and one copy on CD ROM** in Microsoft Office or Adobe Acrobat (PDF) format of the Technical and Cost Proposals. The proposals will not be received any later than **3:00 PM on April 14, 2008**. The Technical Proposal and Cost Proposal must be clearly labeled "Chronic Illness Demonstration Project Technical Proposal" and "Chronic Illness Demonstration Project Cost Proposal", and should be in two distinct parts, separately sealed and identified. **No cost or pricing information should be in a bidder's Technical Proposal.**

Responses to this solicitation should be clearly marked "Chronic Illness Demonstration Project RFP" and directed to:

Jay Laudato
Assistant Director
Division of Financial Planning and Policy
NYS Department of Health
99 Washington Avenue, Suite 720
Albany, NY 12210

It is the bidders' responsibility to see that bids are delivered to 99 Washington Avenue Suite 720 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 Suite 720 will not be considered. **No proposals will be accepted by fax or electronic mail.**

- 1) The Bid Form (**Attachment 10**) must be filled out in its entirety.
- 2) The responsible corporate officer for contract negotiation must be listed. This document must be signed by the responsible corporate officer.
- 3) All evidence and documentation requested under **Section H, Proposal Requirements** must be provided at the time the proposal is submitted.

During the bid evaluation process, the Department may require clarifying information from a bidder for the purpose of assuring the Department's full understanding of the bidder's responsiveness to the RFP requirements. This clarifying information must be submitted in writing in accordance with the format set forth in this RFP and will be included as a formal part of the bidder's proposal. Clarifying information will not amend the bidder's proposal.

The Department is not responsible for any costs incurred by bidders prior to the issuance of a contract.

4. 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 bidder.
- c. Adjust or correct cost or cost figures with the concurrence of bidder if errors exist and can be documented to the satisfaction of DOH and the State Comptroller.
- d. Negotiate with vendors responding to this RFP within the requirements to serve the best interest of the State.
- e. Eliminate mandatory requirements unmet by all offerers.
- 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

1) Start Up and Enrollment Payments

The State will pay the contractor a one time payment for start up and enrollment as provided in the contractor's proposal and Attachment 8 of the RFP.

Upon successful completion of start up, the contractor will submit one (1) voucher for payment of approved start up and enrollment costs. Payment to the contractor shall be made promptly after receipt of such voucher that is satisfactory to the DOH and the Office of the State Comptroller.

2) Operations Payments

The State will pay the contractor for full and proper performance of the administration of care coordination functions in the RFP as amended by documented Questions and Answers. Payments for the care coordination functions will be made monthly based on the contractor's approved monthly care coordination fee for each enrolled intervention beneficiaries as provided in the contractor's proposal and Attachment 8 of the RFP.

The monthly payment will be based on the number of enrolled intervention beneficiaries as of the last business day of the month and the approved monthly care coordination fee (MCCF). Any disenrollment that occurs during a month will be made effective the first day of the following month in which status change occurred and paid as such. In the case where a former intervention enrollee chooses to re-enroll in the care coordination program, eligibility for payment will begin the first business day of the following month.

The contractor will submit monthly voucher for the administration of care coordination functions accepted and approved by the State. The State upon the receipt of a properly completed voucher will pay the contractor the adjusted payment as provided in the contractor's proposal and Attachment 8 of the RFP.

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.

At a date, yet to be determined the Department reserves the right to provide reimbursement for the monthly care coordination fee via the Medicaid eMEDNY payment system.

6. TERM OF CONTRACT

This agreement shall be effective upon approval of the NYS office of the State Comptroller. It is the intent of DOH to award a three-year contract for the period October 1, 2008 through September 30, 2011

This agreement may be cancelled 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, bidders may request a debriefing of their proposal. Please note the debriefing will be limited only to the strengths and weaknesses of the bidder's proposal, and will not include any discussion of other proposals. Requests must be received no later than three months from the 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 12).

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:

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.

J. APPENDICES FOR CONTRACT

The following will be incorporated as appendices into any contract 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 Proposal
- ❑ APPENDIX C - Proposal
The bidder'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
 - **DB-155** – Certificate of Disability Benefits Self-Insurance
- Appendix H - Health Insurance Portability and Accountability Act (HIPAA)