

**Chronic Illness Demonstration Projects RFP**  
**Questions and Answers**  
**March 24, 2008**

**Part B. Background.**

**1. Please provide detail regarding the State's definition of a medical home. Who is the medical home entity, the contractor or the PCP?**

**A.** A medical home may be a primary care practitioner or clinic that has an ongoing relationship with a patient and provides primary and preventive care, and care coordination for all medically necessary medical, specialty and behavioral health care and community resources the patient may need.

**Part B. 1. Beneficiary Eligibility**

**2. Please provide State-endorsed descriptions of the Comprehensive Medicaid Case Management (CMCM) Program.**

**A.** NYS has eight Comprehensive Medicaid Case Management programs. Each CMCM provides case management services for a distinct target population. Case management services are conducted to assist persons eligible for medical assistance (Medicaid Eligible) to gain access to needed medical, social, educational, and other services and specifies in accordance with a written case management plan.

Several NYS Departments and Agencies are touched by case management programs funded by Medicaid, including the: Office of Alcohol and Substance Abuse (OASAS), Office of the Medicaid Inspector General (OMIG), Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), NYS Department of Education (SED), NYS Department of Health (DOH) and NYC Human Resources Administration (HRA) and several Local District Social Services Agencies (LDSS).

The CMCM programs include The CMCM programs include:

- OMRDD- Medicaid Service Coordination (MSC) Program
- OMH- Case Management Program
- DOH- Early Intervention (EI), Service Coordination (SC) Program
- DOH- AIDS Institute (AI), Community Follow-Up Program (CFP)
- OMIG- School Supportive Health Services Program (SSHSP)
- HRA/LDSS- Teen Age Services (TASA)
- LDSS- CONNECT program
- LDSS- Neighborhood Based Alliance (NBA)

**3. Will the State provide contact information for assigned CMCM Program staff?**

**A.** No.

**4. How will a CIDP know if a beneficiary is enrolled in a CMCM?**

**A.** The DOH will provide the CIDP detailed Medicaid claims information on each enrollee once written consent has been obtained. If a beneficiary is enrolled in CMCM it will be evidenced by the presence of CMCM rate codes.

**5. Please provide the CMCM costs, for their inclusion in the CIDP cost and savings arrangements.**

**A.** Due to HIPAA and Medicaid confidentiality laws and regulations, DOH will not be providing any additional data for proposal preparation. However, DOH data has demonstrated that there are a relatively small number of patients in the target population that are receiving CMCM. (Refer to RFP, page 10 Data Exchange Application)

**6. Under HIPAA would a CIDP be considered a business associate?**

**A.** The CIDP would be a business associate and would have to apply for and obtain a Data Exchange Agreement. In addition the HIPAA Business Associate Agreement (BAA) would also have to be

completed as part of the contract. Some of the providers in the CIDP may already be NYS Medicaid enrolled providers and would be covered entities.

**7. Please provide State-endorsed descriptions of the Restricted Recipient Program.**

**A.** NYCRR Title 18. 360-6.4 Restriction of recipient access to services (recipient restriction program). The social services district and the department may restrict a recipient's access to Medicaid care and services if, upon review, it is found that the recipient has received duplicative, excessive, contraindicated or conflicting health care services, drugs, or supplies. In such cases, the social services district and the department may require that the recipient access specific types of medical care and services through a designated primary provider or providers.

A recipient may be restricted to a number of providers including: a primary medical provider (Physician, Physician Group, Nurse Practitioner) or clinic, which also controls access to pharmacy, laboratory, durable medical equipment and non-emergency transportation services; Dentist or Dental Clinic; a Pharmacy and/or a Pharmacy for infusion, compounding and other specialty care; Inpatient Hospital and Durable Medical Dealer.

**8. How will patients with restricted Medicaid be assigned?**

**A.** Restricted Recipients will be identified by the case finding algorithm and provided to the CIDP as part of their target population. If when contacted by the CIDP, the restricted recipient voluntarily agrees to enroll in the CIDP, it will be the responsibility of the CIDP to assist the restricted recipient to contact their Local Department of Social Service or NYC Human Resources Administration to change the provider restriction to a restricted provider within the CIDP network.

**9. Will DOH furnish to the successful CIDP entity lists of eligible patients with specific name and address information which would be used in outreach efforts to enroll the eligible patients in the demonstration?**

**A.** Yes. The DOH will provide each demonstration a list of beneficiaries and demographic information including, name, client identification number (CIN), date of birth, and most recent address of record.

**10. What if the DOH list of potential enrollees includes patients that we are currently serving?**

**A.** DOH anticipates that participants in the CIDP's health care system and community provider network will have many prior contacts with the potential enrollees on the list. The previous contacts should facilitate the CIDP in locating and engaging these beneficiaries for enrollment.

**11. When will the CIDPs be provided detailed claim information on beneficiaries who have voluntarily agreed to enroll in a CIDP?**

**A.** Each CIDP will be required to send DOH an attestation and list of enrollees for whom they have obtained their written consent. DOH will then provide the CIDP three years of Medicaid detailed utilization and eligibility claims history, or any portion available on individual enrollee. The schedule for these events has yet to be determined.

**12. Will CIDPs be provided additional lists of potential enrollees to enroll in the CIDP??**

**A.** Yes, Refreshment Populations of potential enrollees determined by the case finding algorithm will be provided on a yet to be determined schedule. As with the initial population, contractors will be provided demographic information for CIDP enrollment and consent of the beneficiary.

**Part B. 2. Conditions of Beneficiary Participation**

**13. How is beneficiary eligibility for the CIDP programs defined?**

**A.** The CIDP legislation mandated that the CIDP would be for beneficiaries with chronic medical and/or behavioral health illness who are exempt or excluded from mandatory managed care and who voluntarily agreed to enroll in a CIDP. Eligible beneficiaries will be identified based on a review of their Medicaid utilization claims history by a predictive modeling case finding algorithm.

- 14. If a managed care plan is awarded a CIDP, would they be able to provide the enrollee care through the managed care plan?**  
A. No, CIDPs are for beneficiaries who are exempt or excluded from mandatory enrollment in a managed care plan. CIDP enrollees will continue to receive their health care services by Medicaid Fee for Service enrolled providers.
- 15. Will enrolled beneficiaries continue to have free access to all Medicaid providers?**  
A. Yes, a demonstration may not limit or impair a beneficiary's access to Medicaid services to which a beneficiary is entitled.
- 16. In addition to the MCCF payment, may the CIDP bill for the provision of Medicaid allowable services, e.g. medication management provided by a physician or nurse practitioner?**  
A. The CIDP will be paid the MCCF for the care coordination services provided each actively enrolled beneficiary. The CIDP may also be reimbursed for the provision of a Medicaid covered service for an enrollee: if the service has been ordered by a practitioner and is medically necessary, if the patient elects to have the CIDP entity provide the service, and if the CIDP entity is an enrolled Medicaid provider of the service prescribed for the enrollee.
- 17. Will the state consider allowing oral consent if a pre-approved consent is read to the potential participant and their agreement recorded?**  
A. No.
- 18. In how many languages will the DOH consent form be provided?**  
A. The DOH consent form will be provided in English and Spanish. If other language translations are required, it will be the responsibility of the individual CIDP to have the DOH consent form translated. DOH will then have to review and approve all translated consents.
- 19. Will CIDP entities be able to share patient information, including chemical dependence?**  
A. Yes. The consent consists of two components. The first component is for the patient to agree to participate in the CIDP. The second component includes an authorization to release health information on the patient. The authorization to release will allow the CIDP to obtain and share health information on the enrollee. The authorization to release component of the consent also includes a section where the enrollee may elect to have HIV/AIDS and Drug and Alcohol information disclosed.
- 20. Does the informed consent expire after one year?**  
A. Yes. The consent will have to be renewed annually.
- 21. Will the DOH inform eligible beneficiaries and Medicaid providers about the CIDP program?**  
A. The DOH will provide each CIDP a Medicaid Provider Letter as an introduction to the CIDP program and to request they encourage their patients to enroll. The DOH will also provide each CIDP a letter of introduction for eligible Medicaid beneficiaries encouraging them to enroll in the CIDP when contacted. All expenses of preparing and mailing these letters will be the contractor's.

### **Part B. 3. Target Population and Geographic Regions**

- 22. Does the DOH know what percentage of the assigned patient population is homeless?**  
A. No, however DOH anticipates there will be a substantial number of homeless beneficiaries included in the target population.
- 23. Does DOH expect the cost of obtaining housing for homeless beneficiaries to be paid by the CIDP out of the MCCF? What is the State going to offer in regards to housing? Are discussions being held with Department of Homeless Services and the NYC Department of Housing Preservation and Development to develop a state-wide understanding of the need in regards to this demonstration program?**

A. No, the CIDP programs are currently limited to health care expenditures. The DOH anticipates that entities will collaborate with their community providers and will work with other funding sources to fund and meet the social needs of CIDP enrollees.

**24. Will any NY/NY III housing be dedicated to this population and/or will this population receive priority to this housing?**

A. No.

**25. Will undocumented aliens be eligible to enroll in a CIDP?**

A. Undocumented aliens will be excluded from CIDP enrollment.

**26. Would beneficiaries institutionalized in an OMH licensed community residence, who are receiving restorative services, be excluded from the enrollment in a CIDP?**

A. Yes.

**27. Would an OMH licensed housing provider be an eligible bidder?**

A. OMH licensed providers are eligible bidders, however the entity must be able to meet all of the requirements of the RFP.

**28. May a bidder submit a proposal that targets a specific population (i.e. homeless)?**

A. A bidder may propose a specific program; however the CIDP will still be required to meet the average minimum monthly enrollment target of 500 in the NYC Metro Area CIDP Region and 250 in the other six CIDP regions.

**29. Are beneficiaries currently enrolled in an Assertive Community Treatment (ACT) program and a Managed Addiction Treatment Services (MATS) program excluded on the data in Attachment 2?**

A. Yes, they are excluded.

**30. Does Attachment 2 data include disabled beneficiaries who are currently Medicaid FFS until they become eligible for Medicare? Does DOH have any projections on the number of beneficiaries, based on Attachment 2 data that will be affected and required to disenroll from a CIDP?**

A. DOH does not know the number of individuals included in Attachment 2 that are disabled and are waiting to become eligible for Medicare. DOH is aware that there will be some enrollee attrition from the Medicaid program and the CIDPs due to a number of reasons (death, loss of Medicaid eligibility, institutionalization, etc). DOH has taken enrollee attrition into consideration when determining the relatively small sample size required of a CIDP.

**31. For individuals that are newly eligible for Medicaid FFS and do not have any claims history, will they be excluded from the CIDPs?**

A. Initially, these individuals will not be included in the pool of potential eligibles because they have no prior claims history and are not high risk. However, after a six to nine month period if an individual's claims indicate high utilization of health care services they would be included in a refreshment population.

**32. Is that absence of utilization an indicator that is being measured?**

A. No. The DOH look back period of claims history is three years. If there is an absence of utilization by a beneficiary it is a good indicator that they will not have utilization in the future.

**33. Please provide detailed paid claim utilization data by level of care with matching units, admits/cases, membership, and IBNR. Where it is possible, can the detailed utilization be separated into primary, acute, specialty, behavioral and long term care?**

A. DOH is unable to provide any additional paid detailed utilization claims data. Please refer to question 5.

- 34. In tables 7 and 8, can the behavioral inpatient be broken out from the total inpatient?**  
A. No.
- 35. Did the DOH utilize a definition of psychiatric categories identified by specific ICD-9 codes to be included in the CIDPs?**  
A. No. DOH did not select or define any specific ICD-9 codes to be included or excluded from the Medicaid claims data.
- 36. Will the DOH further breakdown the data in Attachment 2 to provide: unduplicated numbers of eligible persons by primary, secondary, etc. diagnoses? In addition will the DOH provide a duplicated breakdown of eligible beneficiaries by diagnosis? Can a list of patients be provided by zip codes and by county?**  
A. Using the predictive modeling case finding algorithm the tables in Attachment 2 provide a representative population of high cost, high risk beneficiaries who will be identified for the CIDPs. Further breakdown of this population will not be provided to bidders.
- 37. Will the state make their data sets (and/or algorithm) available to organizations for further actuarial analysis?**  
A. No.
- 38. Will enrollees be identified based on State-wide data for the purposes of the case-finding algorithm, rather than only hospital specific data?**  
A. Enrollees will not be identified based on state-wide data, but rather based on the data for the contractor's geographic catchment area and participating provider network.
- 39. How often will data and enrollee risk scores be updated to assist with both continued recruitment and also risk-score based patient progress? If data are frequently updated (e.g. monthly) and an eligible enrollee's risk score drops below 50, will this person still be eligible for enrollment? In other words, is eligibility based on a "one-time" risk score?**  
A. DOH will utilize the most recent data available (2008, with at least a 3 month claims lag) to provide contractors potential enrollees with risk scores of 50+ for the past year. Contractors will also be provided "contingent" risk scores for patients who would have a risk score of 50+ if they have a hospital admission in the next 2 months (this would enable enrollment of patients at the time of the "future" admission). DOH will run the risk score algorithm every 2 months.
- 40. It is possible that the average eligible enrollee risk score may differ substantially from bidder to bidder, with one bidder having an average eligible enrollee risk score of close to 50, and another closer to 100. Higher risk scores may indicate that eligible enrollees are more costly, and also more challenging to enroll and/or care for.**  
A. DOH's analysis suggests this is unlikely. Attachment 2 provides information at the borough level in New York City and at the metro/county level for non-New York City to inform and assist bidders. Contractor's performance will be evaluated based on comparison of a control group selected for contractors.
- 41. Beside patient risk scores, will there be other patient characteristics considered such as cost or medical co-morbidities when matching individual and intervention and control group members?**  
A. DOH will be looking at multiple factors, including but not limited to: gender, age race/ethnicity, diagnostic information, etc.
- 42. What outcomes will the State appointed evaluator use to evaluate patient and program progress and success, and what tools and methods will be used to do so?**  
A. The CIDPs will be fully evaluated. The methodology, process and outcomes measures are still under development.

**43. If a bidder has a higher- than-average risk score burden among its eligible enrollees, how will this be dealt with (e.g. Lower enrollment requirement, negotiation of an increased per member per month fee)?**

**A.** Eligible enrollees with risk scores of fifty or higher will be randomly assigned by the DOH, to an intervention and control group which should result in evenly distributed risk scores.

Contractors will be required to meet the DOH average minimum monthly enrollment rates of 500 in the Downstate, NYC Metro Area CIDP and 250 enrollees for the Upstate CIDP Regions and for Long Island and Westchester Counties CIDP Regions.

Contractors will not be able to negotiate an increase in the MCCF. Payment for all CIDPs will be based on the monthly care coordination fee proposed by the bidder in their Financial Proposal Response.

#### **Part B. 4. Geographic Region and Catchment Area Requirements**

**44. Are Westchester and the Long Island counties combined into one CIDP Region?**

**A.** No. Westchester County is one CIDP Region. The Long Island Counties are a separate CIDP Region.

**45. How will patients be assigned to bidders? Is patient assignment to bidder/catchment area based on patient place of residence zip code, or by the hospital(s) from which the patient has sought the majority of their past health services?**

**A.** Using the case finding algorithm, potential enrollees will be assigned based on the patient's place of residence and prior contact with bidder's provider network as defined on the bidder's Technical Proposal Form: Proposed CIDP Catchment Area. After contract award, DOH will work with each contractor to meet the proposed patient conditions of prior linkage to the contractor. DOH will then provide a target population eligible for enrollment located within the catchment area of the network of the contractor.

**46. A multi-hospital system is the official bidder for this demonstration project. Can this bidder have 500 patients across the entire multi-hospital system, or is it expected that each individual hospital will have a patient census of 500?**

**A.** Yes, a multi- hospital system may have an average monthly enrollment of 500 enrollees across the entire system as long as the multi-hospital system is within one CIDP Region. Using Attachment 2, if an eligible bidder (in the NYC Metro Area CIDP Region) and the entities within the bidder's health care system and community network of providers has served a minimum of 700 patients; the bidder may submit a proposal. The proposed CIDP must be able to maintain a monthly average minimum enrollment of 500 enrollees.

Eligible bidders in the Upstate CIDP Regions and in Long Island and Westchester Counties CIDP Regions must have served at a minimum 350 patients and must maintain an average monthly enrollment of 250 enrollees.

**47. Is it possible for a multi-system hospital to cross CIDP Regions?**

**A.** No, a proposal can not combine CIDP regions.

**48. May a bidder submit a proposal for only a portion of a CIDP Region?**

**A.** Yes.

**49. The Attachment 2 tables indicate that some of the MSAs in Upstate New York have less than 1,000 patients who have risk scores above 50. Since enrollment is voluntary, the CIDP will have to engage over 50% of the clinically eligible population to ensure that a minimum enrollment of 500 is assured. Would the state consider combining these regions?**

**A.** Upstate CIDP Regions and Long Island and Westchester Counties CIDP Regions average monthly minimum enrollment has been reduced to 250 enrollees; the maximum enrollment is now

300 enrollees. CIDP Regions may not be combined. **A bidder will be disqualified if a single proposal submission includes more than one CIDP Region.** Please refer to the RFP Amendment Set 1 for more information.

**50. If patients are assigned to a bidder's hospital and are not primarily seen by that facility, is it expected that the patient continue care with their preferred provider at a different institution or is it expected that the patient would move if the patient agrees, to the bidder's facility for care? If this is the case, what is the state's expectation of the non-bidder's responsibility to collaborate with the project? What proportion of patients might this impact?**

**A.** The initial list of potential enrollees provided a CIDP will include patients that have met the CIDP catchment area and linkage requirements proposed by the CIDP contractor. These patients will have been served by the CIDP's hospital and ambulatory providers as well as by other hospitals and ambulatory providers. DOH anticipates that as the CIDPs reach out to these beneficiaries they will develop programs and the capacity to meet their comprehensive needs. DOH fully anticipates that some enrollees may use one facility for primary care, and another institution's substance use treatment services, etc. However, a CIDP may not limit the beneficiary access to any Medicaid enrolled provider for medically necessary services they are entitled to.

**51. What will be the lag time on the utilization data for treatment group beneficiaries that will be provided to contractors?**

**A.** The claims lag is approximately 3 months.

**52. For the purposes of preparing a response to the RFP, can contractors have access to more information about the beneficiaries listed as their own patients?**

**A.** No.

**53. Will bidders have access to the Statewide Medicaid data before the proposal is due? If so, when will bidders have such access? This will allow bidders to better assess the needs of the high-risk patient population in order to best craft an appropriate intervention.**

**A.** No.

**54. How recent will the State Medicaid data be from which eligible enrollees are identified? The concern is that some potential enrollees will have enrolled in managed care plans prior to the demonstration project start if the data is not as up to date as possible.**

**A.** DOH will utilize the most recent data available (2008, with at least a 3 month claims lag) to provide each contractor a population of potential enrollees. Persons currently enrolled in managed care will be excluded in the most recent data set. DOH anticipates that there will remain a population in the FFS environment that is eligible for enrollment in the CIDPs who for a variety of factors (i.e. homeless, HIV positive, etc.) do not enroll in managed care. CIDP enrollees will be exempt from auto enrollment in a managed care plan while they remain enrolled in a CIDP.

**55. Will successful bidders have access to Medicaid FFS expenditures and utilization specific to the enrolled population inclusive of both paid and unpaid claims?**

**A.** Yes, DOH will provide Medicaid claims data for the enrolled population, on a yet to be determined timeframe.

**56. How will homeless patients be assigned?**

**A.** Homeless beneficiaries will be identified based on the last available residence information in Medicaid files and/or contact with provider network. They will be assigned as part of the CIDP's potential enrollment population as determined by the case finding algorithm.

**57. What data elements will be available to the CIDP in real time and which will be subject to a lag; and if the latter, can you provide an estimate of the lag time?**

**A.** There will be no Medicaid data elements available in real time. Medicaid claims data will be lagged approximately 3 months. CIDPs should not rely on Medicaid data for ongoing management of CIDP enrollees,

**58. How often will the State run the risk score algorithm and provide updated eligibility and claims files to the vendor?**

A. DOH will run the risk score algorithm every 2 months. Updated Medicaid eligibility and claims data will be provided on a schedule yet to be determined.

**59. Will Medicaid data include beneficiary phone numbers?**

A. No. DOH will provide the most recent address on file for each potential CIDP enrollee. Obtaining telephone numbers will be the responsibility of the contractor.

**60. Will we receive lab results?**

A. No. Laboratory data is not available on the MMIS claims files, and is not collected by the DOH.

**61. Will the DOH provide a training session on what is included in Medicaid claims data and how to use it?**

A. Yes.

**Part C. Detailed Specification**

**62. What is the State's data transfer capability and what format do they currently use to support data transfer?**

A. DOH is able to transfer in different formats, via CD, or electronic transfer.

**63. Does an entity have to have Health Information Technology (HIT) or electronic health records (EHR) in place to submit a proposal or can it be done as a follow-up activity? Do the network participants and partners have access to electronic health records also?**

A. No, DOH does not expect that all selected contractors and their partners will have full HIT and/or electronic health record (HER) capacity at the time of award. However, HIT will be extremely important for data sharing among providers and may be one of the critical element for success in the management of 500/250 complex patients across the full array of services and providers required to meet their needs.

**64. Does DOH anticipate enrollees to remain enrolled for the three year length of the contract? Does DOH expect enrollees to graduate after a period of care management with new enrollees taking their place?**

A. DOH does not have a required enrollment period for enrollees or expectations of enrollee graduation from care management. These decisions would be made by the individual CIDP.

**65. Is the bidding entity required to be an Article 44 HMO licensee or an Article 49 licensed insurance company?**

A. New York State licensed Article 44 managed care plan providers are eligible bidders. Article 49 licensed insurance companies are not an eligible bidder.

**66. Will proposals be accepted from entities other than those listed as Eligible Bidders in the RFP?**

A. No. CIDP eligible bidders were mandated by the CIDP legislation.

**67. What are the licensure/certification requirements of the telephonic Care Manager?**

A. DOH does not have any licensure/certification requirements for a telephonic care manager. Bidders must determine and propose the qualifications that would best be suited to manage the medically and behaviorally complex target population.

**68. Are affiliations and partnerships with health providers and community based organizations required to be established, prior to submitting a proposal?**

A. Yes, please refer to the RFP, Section H. 1. 4). page 15.

- 69. Does the bidder need to identify subcontractors in their proposal submission?**  
**A.** Primary bidders utilizing a subcontractor to undertake a specific function in the conduction of the CIDP must submit a letter of commitment from the subcontractor in the bidder's proposal stating what services the subcontractor will provide the CIDP. If selected the DOH must review and approve all awardees subcontractors' contracts.
- 70. Does the bidder have to have a Memoranda of Agreements (MOA) in place to submit a proposal?**  
**A.** It is DOH's expectation that entities that submit a proposal to manage this complex disenfranchised population will have history serving these patients and understand that collaboration is necessary to meet the medical, behavioral and community needs of this population. A letter of commitment must be included to demonstrate that collaboration and commitment of integrated health systems/community network providers.
- 71. Is DOH expecting formal governance arrangements beyond those which currently exist within an integrated care system??**  
**A.** No.
- 72. Is DOH requiring prime bidders to provide any risk/shared savings and funding allocation information for entities/subcontractors or participants in the integrated health system or provider network?**  
**A.** No.
- 73. In respect to ongoing care management of enrollees, the CIDPs will need to maintain a care management/MIS record system to coordinate care. What are the anticipated components of such a system?**  
**A.** Each individual bidder must determine the data management system and processes that will be used to accommodate their proposed CIDP that also meet the technical proposal requirements of the RFP.
- 74. Please clarify what information will be gathered and made available for electronic health record refinement/development.**  
**A.** DOH will provide each CIDP Medicaid claims and eligibility data (on a yet to be determined basis) for beneficiaries who have elected to enroll in a CIDP. It will be the determination of the individual CIDPs what types of data will be collected to meet the DOH reporting requirements and to manage the enrollee's care coordination and care management activities.
- 75. When will bidder have the quality reporting form and data points required in order to map into their Information Technology infrastructure?**  
**A.** Awarded contractors will be provided DOH program elements during the implementation period.

#### **Part E. Program Evaluation**

- 76. Is Institutional Review Board (IRB) Approval required for the CIDPs?**  
**A.** In consultation with the NYS Department of Health IRB it was determined that an IRB approval was not needed. Due to the fact that both intervention and control group members will be receiving the usual standard of care.
- 77. According to the RFP, enrollment should start in Month 4 and average 500-550 per month. Does that mean that DOH anticipates a total sample size of 500 x 32 months = 16,000? Please clarify how many months enrollment is supposed to continue at the expected level of 500-550/month.**  
**A.** CIDPs are expected to have a minimum average monthly enrollment of 500 enrollees or maximum of 550 in the NYC Metro Area CIDP Region. In the Upstate, Long Island and Westchester Counties CIDP Regions the minimum average monthly enrollment of 250 enrollees and a maximum of 300. It

is anticipated that enrollees will remain enrolled in the CIDP for a period of time and that the CIDP will have a proportionate sample size.

**78. If a contractor is currently providing case management services to eligible beneficiaries through Comprehensive Medicaid Case Management, Intensive Case Management and Geriatric care management programs, and these beneficiaries end up in the control (or intervention) group, how would this impact the programs evaluation? How would it impact the risk sharing arrangement?**

**A.** For the evaluation and risk /shared savings the cost of these Medicaid services would be included in enrollees' (intervention group members) and the control group members' annual cost expenditures.

**79. In light of difficulties contractors in other demonstrations have encountered in engaging and enrolling beneficiaries, would the Department consider evaluation design modifications that would enable contractors to leverage current patient relationships, particularly those built around existing behavioral health interventions? In this scenario, groups would be randomized by site instead of beneficiary. For example, one ICM program would be compared with another for evaluation purposes.**

**A.** No.

**80. Because evaluation will be performed by an independent party, will bidders/investigators have the opportunity to publish demonstration results in peer-reviewed literature? Will bidders be permitted to conduct any evaluation method independent of the State-assigned evaluator (e.g. qualitative interviews or other form of data collection)?**

**A.** The official evaluation of the CIDPs will be conducted by the DOH and/or a third party evaluator designated by the DOH. Selected contractors may conduct their own evaluation of their CIDP. However, any outcomes/ findings or evaluative reports or articles for publication must be submitted to DOH for review and approval and may not be released or shared prior to the release of the DOH final evaluation.

#### **Part F. Contractor Payment.**

**81. What signifies enrollment – does a patient become “enrolled” by signing the consent form, even if they do not become engaged and receive an intervention?**

**A.** By voluntarily signing the consent, an individual has agreed to enroll in the CIDP. A consented enrollee must then have a health risk assessment within 30 days and an individualized service plan completed shortly thereafter. To maintain active enrollment and for a CIDP to be paid the MCCF, an enrollee must have met the monthly threshold of one face to face or two other intervention types with each individual enrollee per month. A minimum of one face to face intervention must be provided each enrollee per quarter. In the Quarterly Report, contractors will be required to report enrollee specific information on interventions provided enrollees which will be verified by DOH. (Refer to the RFP, Reporting Requirements, page 10)

**82. The RFP discusses the need for “regular patient contact”. How will this be defined: face-to-face meetings, telephonic contact, written contact, electronic contact?**

**A.** In their proposal response, each bidder is required to provide detailed information on their planned program interventions designed to meet the need of this behaviorally and medically complex population.

**83. In addition to the MCCF payment, may the CIDP bill for the provision of Medicaid allowable services, e.g. medication management provided by a physician or nurse practitioner?**

**A.** Yes, if they are a NYS Medicaid FFS enrolled provider they may receive Medicaid reimbursement for any Medicaid covered, medically necessary service provided a beneficiary they are entitled to.

**84. Can you elaborate as to the anticipated availability of federal matching funds?**

A. DOH must submit a waiver to CMS and receive approval for federal matching funds. If federal matching funds are received the matching funds will be used to offset State funding. Refer to RFP Amendments Set 1.

**85. Please confirm that the maximum budget a vendor can submit per CIDP demonstration program is \$1.75 million per contract year.**

A. For CIDPs conducted in the Downstate NYC Metro Area CIDP the maximum bid is \$1.75 million per year. For CIDPs conducted in all of the Upstate CIDP Regions and Long Island and Westchester Counties CIDP Regions the maximum bid is \$925,000 per contract year.

**86. Do you have a minimum award amount?**

A. No.

**87. If an entity is awarded a CIDP and is also a FFS Medicaid enrolled provider, will they still be able to provide Medicaid services to enrollees?**

A. Yes, if the enrollee selects to use the CIDP provider for Medicaid reimbursable services. The CIDP funding is for care coordination and management services.

**88. Will a CIDP get paid the MCCF based on their proposed enrollment target or the actual number of enrollees? Will the CIDPs be able to bill separately for the required face to face contacts?**

A. The CIDPs will be paid on a monthly basis for the MCCF for those beneficiaries who have consented and are actively enrolled in the demonstration. Active enrollment requires a minimum of one face to face or two other types of interventions per enrollee per month. One face to face contact must be made each quarter. Each CIDP will provide a quarterly report, by individual enrollee, by number and type of interventions provided. DOH will perform onsite audits to verify quarterly reporting. CIDPs will not be able to bill DOH separately for a required CIDP face to face contact.

**89. What is the Quality Reporting and Performance requirement?**

A. The CIDP must be able to provide a documentation of a completed health risk assessment and an updated individualized service plan for each enrollee within three months of a beneficiary's enrollment date. CIDPs not able to produce this documentation for 95% of enrolled patients will have to refund the DOH 10% of the at-risk MCCF.

**90. Will the DOH provide Medicaid eligibility information on enrollees initially and on an ongoing basis?**

A. Yes.

**91. Will CIDPs be reimbursed for enrollees who have a lapse or lose their Medicaid eligibility and have been provided CIDP service?**

A. A reconciliation to account for lag in updating of Medicaid eligibility files will be done by DOH on a yet to be determined schedule. For those enrollees who maintain eligibility the CIDP will receive payment.

**92. Will the DOH recover the MCCF for those who have lost the Medicaid eligibility?**

A. Historically, DOH has not recovered care management demonstration's MCCFs, however it will be at DOH's discretion to do so.

**93. How can a CIDP entity assure that an enrollee is still Medicaid eligible?**

A. Verify the beneficiary's eligibility with the Medicaid Eligibility Verification System (MEVS).

**94. How can a CIDP assist an enrollee to maintain their Medicaid eligibility?**

A. Each beneficiary's Medicaid eligibility file will include the beneficiary's eligibility segment with a start and end date. CIDP should remind and assist enrollees to complete the recertification process to avoid a lapse in Medicaid coverage.

**Part F. 1. Start Up and Enrollment Costs**

**95. Please clarify what start up vs. enrollment costs are. Will these costs be included in the \$1.75 Million?**

**A.** 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. These funds will be included in the \$ 1.75 million (NYC Metro Area CIDP Region) or \$925,000 (All other CIDP Regions) of the first contract year.

**96. Are contractors at risk for those beneficiaries who are on their roster but who decline participation in the intervention?**

**A.** No, the contractors are only at risk for those beneficiaries who have voluntarily consented to enroll.

#### **Part F. 5. Risk Arrangement**

**97. Would the state re-consider calculating cost savings on the average rather than individual level?**

**A.** No.

**98. How will DOH address the enrollees who are in the program for a limited period and disenroll, lose eligibility or die? Will DOH's methodology for assessing the CIDP's savings reduction impact require a minimum period of enrollment for each individual patient included in the analysis? Will enrolled patients who become unreachable count towards the provider's quality and risk calculation?**

**A.** The final criteria and methodology for determination of risk and shared savings is still in development.

**99. What is the responsibility of the contractor to re-engage patients who initially enrolled but become unreachable? What is the risk to a contractor if a patient leaves or is lost to the program?**

**A.** DOH will work with each CIDP and provide guidance on enrollee disenrollment after what has been determined to be a reasonable effort.

**100. If subsequent to enrollment an enrollee becomes institutionalized in a nursing home or some other facility will they have to be disenrolled from the CIDP?**

**A.** Yes, if institutionalized the enrollee would then be in one of the excluded categories.

#### **Part F. 6. Shared Savings**

**101. Can NYSDOH elaborate on the methodology for sharing of savings due to improved utilization?**

**A.** Shared savings will be calculated based on a comparison of annual aggregate expenditures of the control group and intervention enrollees.

**102. If the intervention group's annual aggregate expenses are 85% of the control group's annual aggregate expenses, are the shared savings based on 15% or total savings?**

**A.** Shared savings will be based on the total savings.

**103. What costs are clearly included and excluded from the risk and shared savings calculations (i.e. nursing home care, trauma, medical/behavioral/pharmacy needs associated with chronic disease management)?**

**A.** Costs excluded from risk and shared savings calculations include trauma, obstetrical care, and cost for institutionalization. Final determination of all inclusion and exclusion cost criteria is still under consideration.

- 104. Can you elaborate on the operational implications of the different approaches to the calculation of risk and shared savings, post- Year 1?**  
A. Notwithstanding other circumstances, a CIDP would remain operational if it was determined recovery of at-risk MCCFs was required; or if a CIDP were eligible for shared savings.
- 105. How is the DOH going to deal with issues of individual outliers for risk and shared savings?**  
A. The final methodology for exclusion of individual cost outliers is still under consideration.
- 106. Are there any “stop loss” provisions for individual outliers?**  
A. No.
- 107. May a contractor who is eligible to receive shared saving, re-invest the shared savings back into the CIDP?**  
A. Yes, however the contractor's decision to re-invest shared saving into the CIDP would not change the DOH's evaluation of financial success.

### **Section G. Procurement Timeline**

- 108. Would the Department consider extending the very short 2-year time horizon to demonstrate cost reduction?**  
A. The CIDPs will be conducted for three years. (Refer to RFP, page 14)

### **Part H. Proposal Requirements**

- 109. Please provide the State's definition of “the lead entity in the network”.**  
A. The prime contractor. Refer to RFP, page 14.
- 110. Please clarify what types of information DOH is requesting bidders to provide on line access to?**  
A. Ideally, DOH would like to be able to view, by individual enrollee, the care management activities that have been conducted with and on behalf of the enrollees.
- 111. Please clarify if the State intends for the 5 page limit to include the Attachment 6 work plan, or if it is acceptable to provide the work plan as an attachment?**  
A. The bidder may include their work plan using the DOH template as a proposal attachment.
- 112. In submitting the Financial Proposal Forms- Attachments 8 A and B of the RFP Amendments Set 1, does the bidder need to include a detailed budget?**  
A. This contract is paid based on a price not a budget. Payment to the contractor will be based on the price included in the proposal, not the contractor's costs.
- 113. How does a financial proposal receive the maximum points?**  
A. The lowest price proposal receives the maximum score for evaluation purposes and awarding of the contracts.

### **Part H. Method of Award**

- 114. Do you have a projected number of contracts you intend to award?**  
A. There will be a minimum of one award made in the Upstate and Downstate Geographic Region. Awards will be made by Geographic and CIDP Regions until funds are exhausted.

### **General Questions**

- 115. How do Medicaid beneficiaries access transportation services?**

A. Transportation can be provided to medically necessary, Medicaid-covered services. Non-emergency transportation must be prior authorized by the county Social Services Department, or in NYC, the Medicaid Fiscal Agent.

**116. Will the power point presentation from the Bidder's Conference be posted on the website?**

A. The power point presentation will not be placed on the website.

**117. Is the Bidder's Conference attendance list going to be posted on the DOH website?**

A. Representatives from the following organizations attended the Bidder's Conference:

HEALTH & HOSPITALS CORPORATION - BELLEVUE INTERNATIONAL CENTER FOR THE DISABLED INSTITUTE FOR COMMUNITY LIVING UNITED HEALTH GROUP/OPTUM HEALTH U.S. PREVENTIVE MEDICINE MONROE PLAN FOR MEDICAL CARE WELLCARE PSCH INC./ASTRO CARE FEGS REHABILITATION SUPPORT SERVICES HOUSING WORKS VALUE OPTIONS HEALTHCARE ASSOCIATION OF NYS SENIOR WHOLE HEALTH COMMUNITY CARE BEHAVIORAL HEALTH NEWYORK-PRESBYTERIAN HSP CENTERS FOR HEALTH CARE STRATEGIES QUEENS HEALTH NETWORK	THE CARE MANAGEMENT COMPANY/MONTEFIORE MEDICAL CENTER APS HEALTHCARE MIDWEST (INNOVATIVE RESOURCE GROUP, LLC, d/b/a UNITED HOSPITAL FUND (UHF) ST LUKE'S ROOSEVELT HOSPITAL OPTIONS FOR COMMUNITY LIVING CERNER CORPORATION PSCH, INC. MANATT, HEALTH SOLUTIONS SAE AND ASSOCIATES SOUND SHORE HEALTH SYSTEM METROPOLITAN JEWISH HEALTH SYSTEM TRI-COUNTY HOME NURSING SERVICES AMERIGROUP NY, LLC ELLIS HOSPITAL EXPERIENCE HEALTH NEW YORK (U.S. CARE MANAGEMENT) MATRIX PBM MCKESSON HEALTH SOLUTIONS NYU MEDICAL CENTER
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