

Assessment Center RFP Questions & Answers

Question 1: Can you explain the projected numbers on Attachment 18? How does the month 6 number progress to the month 7 number? In the CASA VII total column, how did the DOH arrive at the number 6,907? (It does not work out the same way the upstate numbers do by adding the column to reach a total).

Response: There was a formula error in Attachment 18 of the RFP with respect to CASA VII. A revised Attachment 18 is posted on the Department's web page at <http://www.nyhealth.gov/funding/rfp/0907070849/> for this RFP.

Question 2: Page 6, Introduction - The second bullet on the bottom notes that the project will serve consumers requiring reassessments for LTC service received prior to the contract start date if the reassessment is in the first six months of 2010. This seems to contradict the statute (367-w)(5) which says the section applies to consumers who apply for services after 1/1/2010. Is the bidder expected to perform reassessments on cases receiving services prior to the start date of the contract?

Response: As reflected in the estimates provided in Attachment 18, the **"1st 6 months: New Recipients Only"** are recipients who are newly receiving Medicaid LTC services and include any reassessments of those **new recipients** as necessary. The estimated reassessments for new recipients are included in the first 6 month Assessment Estimates. For CHHAs and LTHHCPs which will have reassessments occurring during this period, the reassessment requirement for recipients receiving services from CHHAs and LTHHCPs are less than 6 months.

The **"Next 6 months of the contract: Full"** as presented in Attachment 18 includes recipients who **have been receiving services prior to the contract date**. These recipients are referred to as "Existing" to LTC (i.e. persons who had been receiving LTC services prior to the contract start date), and any reassessment they require are included in the estimates.

Question 3: Page 25, D.3.b.V.(7) - Is the bidder responsible for contracting with LTC service providers?

Response: No, the contractor will not be responsible for contracting with long term care service providers.

Question 4: Page 23, Workplan - Is there a time limit on how long a bidder should track outcomes for individuals who were denied service? How frequently should this be reported on?

Response: As stated on page 23 of the RFP, ***"Bidders should include a description of a plan through which it will track outcomes of individuals who, through the assessment/reassessment process, are determined not appropriate to receive services that are the subject of this RFP, or who have had previously authorized amounts of service reduced or terminated as a result of reassessment"***. With respect to the length of time a contractor should track outcomes for such individuals, a minimum of six months is viewed as a reasonable timeframe.

Question 5: The contractor is supposed to propose a plan for how it would track outcomes of consumers for whom services were not authorized based on the assessment conducted. Will consumers who are authorized for a lesser amount of hours of service than were requested, be similarly tracked?

Response: Please refer to Page 11 C. 2. which indicates that, *“Additionally, in responding to this RFP, the bidder should propose and describe a system for tracking outcomes of individuals who, based upon assessment findings, had services denied, terminated or approved for lesser amounts than requested”*.

Question 6: General - How much funding has the state allocated for each of the 3 year demonstration projects?

Response: The Department has a general fund appropriation for the first year of the demonstration. However, budgeted funding levels are not identified in an RFP. Bidders are expected to prepare what they believe to be a fair and reasonable estimate of its projected expenses and submit a competitive bid.

Question 7: Page 19, General - How is the bidder expected to remove identifying information from its experience section when the experience itself often identifies the bidder?

Response: If the bidder has provided a letter of intent, the Department will issue the bidder an identification number. The bidder should use this number in all headers and footers in the experience section, and any place within the experience section where the bidder identifies itself by name. Recognition of a bidder based on details of the bidder’s experience will not result in a disqualification, but any use of the bidder’s actual name in these sections will be grounds for disqualification.

Question 8: Page 19 §D.3.a. Document List & General Instructions - The RFP indicates that the proposal “must not contain any identifying information about the bidder.” Please specify the extent to which the bidder’s identity must be hidden. For example, de-identifying experience would be difficult if there is only one organization in the state conducting a specific task.

Response: The bidder’s name, address, trade name or similar information must not appear on any document included in the list. The Department is aware that it may be possible to identify a bidder by the nature of its business. That will not disqualify a bidder so long as its name does not appear.

Question 9: Page 29, Staffing - Based on projected volumes in Attachment 18, should staffing be pro-rated in the first year and if so, how does that impact on the year 2 budget (which is based on the year 1 budget)?

Response: The bidder must structure its bid so that it submits a firm price for each unit of service that it will provide. The successful contractor must complete all work assigned whether or not that work is calculated in the staffing assumptions made by the bidder in constructing the bid.

For example, assume a bidder were to bid \$100 for hypothetical Service Unit “X” based on the volume information in Attachment 18. Assume that the \$100 bid was based on a volume assumption of 1,000 Service Units “X” per year. The contractor would be paid \$100 for each Service Unit “X” required and completed during the

year whether the volume of services were to be 100, 1,000 or 10,000. The contractor's staffing levels would necessarily depend on the number of actual services provided. The bidder needs to detail what staff the contractor will provide and that staff meet required qualifications.

Question 10: Can you provide any additional information regarding payment structure that would be provided to the organization who [sic.] would be awarded responsibility for the Long Term Care Assessment Center services. We would specifically be interested in this information for the Orange & Ulster County Long Term Care Assessment Center.

Response: Please refer to the response to Question #9. That response is applicable to both of the Long Term Care Assessment Center regions.

Question 11: Page 42, General - What time must the proposal be submitted?

Response: Proposals should be received no later than 4:00 p.m. on October 15th.

Question 12: HRA Case managers currently assist HRA Medicaid eligibility specialists in gathering the required documents, particularly with respect to homebound clients. Will the case managers stop assisting HRA eligibility specialists in gathering the necessary documents to establish eligibility?

Response: The Department would not prohibit the Assessment Center from providing assistance in gathering such documents. However, activities associated with Medicaid eligibility determinations remain the responsibility of the local district. It is also noted that it is intended that assessments conducted by the Assessment Center will be for consumers already determined to be Medicaid eligible.

Question 13: The RFP states that the Assessment Center will take over existing personal care cases that are reauthorized within a 6 month period following the start date. What about the cases that are reauthorized after 6 months? In CASA VII, some cases may not be reauthorized for up to a year.

Response: During the initial 6 month period all assessments and reassessments will be the responsibility of the Assessment Center for the specified programs. This includes those who were new during the 6 month start up period and had an initial assessment in the Assessment Center, as well as those who were previously assessed by the local district.

Question 14: At the [bidders'] conference, the presenters spoke of administrative case management and service units (initial assessments, reassessments). The reality on the ground is that the case manager has to be involved in a range of client problems in order to resolve them satisfactorily – (e.g. a bed bug infestation, broken elevators, heat emergencies, etc.). Will the State [sic.] Assessment Center be paid for case management that doesn't fit within the parameters of the administrative case management model?

Response: Contractors will be reimbursed for provision of administrative case management services as delineated on page 28 of the RFP.

Question 15: We understand that the Administrative Case Management activities of the LTCAC (page twenty eight of RFP) do not include providing information on all long term care options or determining which long term care program is appropriate for applicants. Please confirm that this is correct.

Response: Please refer to regulations cited on page 28 of the RFP. Consumers should be informed of options and choices of programs and services that meet their needs in a manner that ensures their health and safety.

Question 16: Can the State Assessment Center [sic.] start working on the assessment process while a Medicaid application is still pending?

Response: An Assessment Center may choose to do so at its own risk should the consumer in question ultimately be determined not to be eligible for Medicaid funded home and community based services. Services provided up to three months prior to a consumer's positive determination of Medicaid eligibility, are reimbursable by Medicaid.

Question 17: In reviewing RFP No.0907070849 for the establishment of a Long Term Care Assessment Center, it is mentioned that the program is contingent on the availability of state funds and availability of Medicaid FFP. There is no further mention regarding compensation for services.

Response: The successful bidder will be compensated based upon the number of Service Units completed during the contract term, multiplied by the amount bid for that service Unit. For further information, see RFP Part D, generally and Part E.6., pages 43 and 44.

Question 18: Would you be able to provide information on how many organizations have expressed interest in the Orange/Ulster center? Did any participate in the Bidders Conference?

Response: Organizations that submitted a letter of intent did not indicate for which region(s) they intended to submit a proposal(s). A list of attendees at the Bidders Conference is presented in response to Question # 50.

Question 19: The personal care reassessment cycle in NYC is once every twelve months, except for split shift and sleep in cases which are reassessed every six months. The caseload of the Assessment Center as described in the RFP would, in fact, be slightly less than half of the center's currently active caseload, leaving the remainder with the district. Is that your intention?

Response: It is expected that the Assessment Center(s) would operate on the basis of the reassessment cycles currently in place in the respective Assessment Center regions. In recognition that many Personal Care Services Program cases are reassessed on an annual basis rather than every six months, the estimated volumes presented in Attachment 18, assumed an overall average reassessment period of every nine months. The numbers presented in Attachment 18 are estimates only.

Question 20: Are the reviews of CHHA assessments nursing reviews of paper only?

Response: Nursing reviews of paper documents would serve as the basis for the 60 day interval of CHHA assessments and service authorizations.

Question 21: Would there ever be a time when CHHA services would be in place for 1 year? Would this require in home nursing and social assessment by the Assessment Center?

Response: Reauthorization of CHHA services would occur in 60 day cycles starting at the end of the initial 60 day period of services.

Question 22: Who is responsible for article 78 proceedings in Assessment Center cases?

Response: The entity awarded the contract will be an independent contractor. Independent contractors are not entitled to defense and indemnification by the state under Public Officers Law §17.

Question 23: Page 6 states that the Assessment Center will be responsible for those not receiving any LTC service. Do you mean to exclude persons being discharged from residential health care facilities (nursing homes) and hospitals?

Response: “those not receiving any LTC service” refers to consumers that do not receive any of the home and community based long term care services identified on page 7 of the RFP.

Question 24: What will be the Assessment Center responsibility in arranging alternate/continued services for persons who providers seek to discharge for non compliance with plan of care or because the home constitutes a hostile work environment due to environmental or social conditions?

Response: Assessment Center responsibilities will vary dependent on the service being provided and the type of provider delivering the service (e.g. licensed home care services agency, certified home health care agency, long term home health care program, etc). The regulations and policy directives governing the Medicaid programs/services being managed by the Assessment Center and the regulations and policy documents governing the providers eligible to provide those services should be consulted for a comprehensive understanding of roles and responsibilities when seeking to discharge a Medicaid recipient for non-compliance with their plan of care or because of health and safety issues.

Question 25: Please clarify the specified populations eligible for 12 month reassessment in Personal Care, in CD-PAP.

Response: Title 18, Section 505.14 provides detail with respect to authorization/reassessment periods for consumers receiving these services.

Question 26: Does the district retain responsibility for Fair Hearings on Medicaid eligibility decisions for Assessment Center cases?

Response: The local district(s) would retain responsibility for Fair Hearings as they relate to Medicaid eligibility determinations.

Question 27: Please clarify the distinction between “participation” and “contribution” of informal supports as part of the Assessment Center activity [D.3.b. v (5), page 25 of 53].

Response: Page 25 of the RFP refers to “participation” as it relates to *informal* supports and “contribution” as it relates to *formal* supports.

Question 28: Will the assessment center be responsible for designing and implementing the recently announced CD-PAP notification for its consumers?

Response: It is anticipated that the Assessment Center would support the local district in notifications to appropriate recipients.

Question 29: Page eleven under section C.1 of the RFP states, “If federal audit(s) find the contractor’s performance has resulted in inappropriate claims for services or expenditures, the contractor shall be financially responsible for any recoupment the federal government imposed on NYS.” Would DOH add a provision that if an audit by the federal or state government determines that a home care agency is financially responsible for any recoupment or fines due to an action or inaction by the long term care assessment center (LTCAC), the home care agency would not be held responsible and the LTCAC would be financially responsible for such recoupment or fines.

Response: No. The contractor under this RFP does not pay for any Medicaid services.

Question 30: If there is a recoupment from a federal audit, will the contractor be able to assess providers for a portion of the monies due? What mechanism is available for the contractor to recoup from a provider?

Response: There will be no need for the contractor to assess providers for the monies due, if any. The contractor will not be paying any providers for any services rendered. Any recoupment for a federal audit under this RFP would relate only to recoupment of claims made by the Contractor.

Question 31: Page 11, C.1. - Can you provide further detail on the financial responsibility of a bidder pursuant to a federal audit?

Response: If conducted, a federal audit may test the contractor’s compliance with federal Medicaid requirements and may also assess whether the contractor actually performed the services for which it was paid. If a federal disallowance is taken against the State of expenditures claimed based on the billing by the contractor for services under the contract, the contractor will be required to reimburse the State for payments made to the contractor for disallowed assessments.

Question 32: Page 11 §C.1. Overview - The RFP states that, *If federal audit(s) find the contractor’s performance has resulted in inappropriate claims for services or expenditures, the contractor shall be financially responsible for any recoupment the federal government imposes on NYS.*

Please clarify the implications to the contractor, for example:

- a. If the contractor uses state guidelines for provision of long term care services, would the contractor still be responsible for any recoupment the federal government may impose?

Response: The bidder does not need this information to develop a proposal under this RFP.

- b. Is the contractor responsible for validating providers’ claims to assure they billed appropriately for approved services?

Response: The bidder does not need this information to develop a proposal under this RFP.

- c. If the contractor identifies potential fraud or abuse, to whom should they make a referral?

Response: The Office of the Medicaid Inspector General, the Attorney General and the DOH project manager for the Contract.

- d. Is there a dollar limitation on the contractor's financial responsibility?

Response: The bidder does not need this information to develop a proposal under this RFP.

- e. Is the contractor's liability limited to the federal share only?

Response: The bidder does not need this information to develop a proposal under this RFP.

- f. Over what period of time would the contractor be responsible for payment?

Response: The bidder does not need this information to develop a proposal under this RFP.

Question 33: As part of the reassessment activities of the LTCAC, if such an assessment is not conducted during the six month-period following January 1, 2010 or the contract start date (see page six of the RFP), does that case remain with the existing social services district? The RFP is unclear on this point.

Response: During the initial six month period only recipients new to Medicaid home and community based long term care services will be assessed by the Center. Any reassessments for those new recipients will also be the responsibility of the Assessment Center. After the initial six month period all consumers (new and existing) will be assessed / reassessed by the Assessment Center.

Question 34: Please confirm the LTCAC will not assess the **initial** need for certified home health aide (CHHA) services or authorize the **initial** 60 days of CHHA services, but will assess the continued need for services **after** the first 60 days and any additional 60-day period.

Response: That is correct

Question 35: Please explain how DOH determined that the LTCAC demonstration would take place in Orange and Ulster counties and the area in Brooklyn served by CASA VII.

Response: The areas selected represent a mix of urban, suburban and rural consumers.

Question 36: Does Attachment 9 require narrative detail?

Response: Attachment 9 does not require narrative detail.

Question 37: Can the table for the Work Plan be made an attachment so it does not count as part of the 30 page limit?

Response: The table for the Work Plan is outside the 30 page limit. It can be submitted without impacting the 30 page limit.

Question 38: In the Work Plan, should each activity be described separately or can they be merged together when they are the same?

Response: Bidders should develop the Work Plan to meet the requirements of the RFP and to demonstrate the bidder's ability to deliver the services required by the RFP.

Question 39: How can the bidder give average monthly travel costs without providing cost numbers?

Response: Please include the good faith estimate of average monthly travel costs in the Cost Proposal. All other information about travel arrangements is to be included in the Technical Narrative.

Question 40: Does the DOH have an estimate on reassessment requests?

Response: Reassessments are included in the total assessment estimates contained in Attachment 18. This attachment also indicates the assumptions used on a program/service-specific basis as to the frequency of reassessments.

Question 41: Does the DOH have an estimate on cases assessed that are denied?

Response: The Department is unable to provide data at this time addressing this question.

Question 42: Is the CHHA assessment a prior authorization for the services?

Response: The assessment center would authorize services following the initial 60 day authorization of services and where indicated, will continue to authorize CHHA services every 60 days thereafter.

Question 43: Can the DOH provide a current list of the providers for each service unit for CASA VII catchment area and the Orange/Ulster catchment area of intent?

Response: We are unclear why such lists would be of value in the preparation of a proposal. Once selected, a contractor's need for provider lists would be addressed.

Question 44: Can the DOH provide the current forms that are required to be submitted electronically to eMedNY for the providers of each service unit, if applicable?

Response: The providers of services have access to eMedNY for billing purposes. The interface between an Assessment Center and eMedNY would be for service authorization purposes. A selected contractor would receive training in electronic submission of service authorizations to eMedNY.

Question 45: The DMS-1 score is currently used to predict Nursing Home eligibility for certain service units. Is the contractor expected to continue to use this assessment form or simply use the PRI provided in the proposal?

Response: With regard to forms used for purposes of nursing home level of care determinations, as is currently the case, the Patient Review Instrument would be the

applicable tool with respect to Assisted Living Programs, the DMS-1 with respect to Long Term Home Health Care Programs and the Semi-Annual Assessment of Members with respect to Managed Long Term Care Plans.

Question 46: Is there a conflict for a provider to review cases in the same area that it also provides service?

Response: Whether or not the bidder is a provider of Medicaid services, it must include in its Conflict of Interest Narrative (D.3.b.VIII) an explanation and plan for how conflicts will be avoided, and what activities and/or administrative structures will be put in place to prevent conflicts of interest.

Question 47: In Attachment 5- Line Item Bid Form-, Part IV, the form asks for Responsibilities and Duties for Additional Hourly Rates for unanticipated activities. Can you please provide examples of potential unanticipated activities?

Response: The Department does not anticipate any activities related to the Assessment Center(s) other than those described in the RFP. However, this is a demonstration and a new function outside of the context of local social services districts. Thus, it is possible that situations may arise that are not accounted for in the RFP, but may need to be addressed in order for required activities to be continued or completed. In the event any such situations arise, the Department requests a commitment from each bidder to an hourly rate for all identified staff that will apply in the event the Department chooses to undertake such unanticipated activities. Each bidder should provide a firm hourly rate for each professional and support staff title that might be involved in such activities. That hourly rate should be the "regular" hourly rate the bidder would charge for such title and is not dependent on the type of activity relevant to such title that a bidder would be asked or authorized to perform by the Department.

Question 48: On page 37 of the RFP, section D.6.g.III, it states that there are penalties for not maintaining experienced staff and that there is information about the penalties in Part F.8. Where can I find Part F.8? (It does not appear to be in the RFP package).

Response: General information about penalties is in Part E.6. Specific penalties will be included in the contracts awarded under this RFP.

Question 49: Should Appendix I (Attachment 27) be submitted with the proposal?

Response: No. The bidder should submit its assurance that it will comply with Appendix I should it be awarded a contract. Appendix I will be signed by the successful bidders and included in the contracts issued under this RFP.

Question 50: Can DOH provide a list of attendees at the Bidder's Conference?

Response: Attendees (in person and telephonically) at Bidder's Conference were as follows: Michael Eisner (NYC HRA), Robert Rosenbloom (New York County Health Services Review Organization - MedReview, Inc.), Doug Hovey (Independent Living, Inc./ IHC, Inc), Marlene Slusser (Medical Transportation Management, Inc.), Aliana Marcia (Medical Transportation Management, Inc.), Mark Ustin

(Manatt Phelps Phillips), Jane Preston (Greenberg Traurig, LLC), Andrew Koski (Home Care Association of New York State), Jay Gormley (Metropolitan Jewish Health System), Arthur Lerman (Public Consulting Group, Inc.), James Terrell (Public Consulting Group, Inc.), Geoffrey Walton (Comprehensive Care Strategies), Paul Jawin (Comprehensive Care Strategies), M. Flen (New York County Health Services Review Organization - MedReview, Inc.), Roberta Alpert (Care Next), Michael Simione (The Jewish Guild for the Blind), Stacey Johnston (Comprehensive Care Management), Michael Garrett (Qualis Health), Elizabeth Rosado (WellCare NY), Tony Shied (IPRO).

Question 51: Is there an estimate of the % of referrals that are geriatric vs. other chronically ill or physically disabled cases?

Response: Geriatric and non-geriatric populations can be considered to be chronically ill or physically disabled. In partial response to the question, as a point of information, presented below is a statewide percentage breakdown of clients over and under the age of 65 as delineated by program/service.

Percentage of Medicaid Recipients in New York State by Age Groups for Calendar Year 2008		
Programs	Age Groups	
	0 - 64 years	65+ years
ALP	(16%)	(84%)
CHHA	(54%)	(45%)
LTHHCP inc. AHCP	(31%)	(69%)
PCS	(27%)	(73%)
CDPAP	(59%)	(41%)
MLTC	(16%)	(84%)
PERS	(24%)	(76%)

Source: NYS Medicaid Data Warehouse

Notes:

- Some of these unique recipients may be enrolled in more than one program.
- PCS, CDPAP and PERS are separated for purpose of this calculation.

Question 52: Can you provide any county level statistics by diagnosis, services required, cost of care and site of care?

Response: The question is vague and it is unclear as to the value of this type of information in preparing a proposal. The RFP seeks to assess consumer needs and authorize services.

Question 53: For home based clients, do you have any statistics by program on the average type of care (home health aid vs. homemaker, etc.) and the average hours of care received?

Response: It is unclear as to the value of such information in the development of a proposal.

Question 54: What are the rules regarding conflicts of interest if a provider of ongoing care management services also performs the assessments? Will such providers be allowed to apply?

Response: Please refer to Part D.1. (page 18) and the parts referred to in that part. Also note the conflict of interest requirements that must be met by the successful bidder in Part D.3.b.VIII.

Question 55: What format is required for data transfers into the state system? Paper based, PDF, flat file, etc.?

Response: It is unclear what “data transfers” are being referred to in this question. However, any data transferred will be in electronic format.

Question 56: What information does the contractor get from NYS on the care provided and in what format (fax, flat file, PDF) is it provided?

Response: It is expected that an Assessment Center will have “read only” access to relevant screens within the WMS.

Question 57: What data integration and type of feeds to or from the providers, programs and governmental agencies will exist?

Response: It is unclear what is being asked. In general terms it is expected that an Assessment Center will have read only access to WMS and will enter service authorizations into the eMedNY system.

Question 58: It is understood that DOH is in the process of developing a unified LTC assessment tool. Will this tool be introduced during the contract? Can we have access to the tool currently in development?

Response: As stated in S 367-w, “Such centers shall serve the purpose of transferring from the social services district to the regional long term care centers responsibility for activities related to the assessment of a person’s need for, and the authorization of, long term care services and programs” As such, in the event a local district in which an Assessment Center operates would otherwise have been required to utilize a uniform assessment tool, the Assessment Center would be similarly required.

Question 59: What is the average number of assessments per recipient?

Response: In addition to any initial assessments conducted for a consumer entering a program or service, sections c.2.a. through c.2.h. of the RFP indicate the reassessment intervals for each program/service.

Question 60: The Long Term Care Placement assessment requires both a SW and RN to fill out portions of the assessment - it is an on-site assessment. Is this required to be a joint visit by the

RN and SW at the same time? What are the requirements for integration of the clinical and social work assessments?

Response: This is a regulatory requirement with the intent that the visits by the LTHHCP RN and the Social Worker be done jointly. It is clear that when a visit is not jointly made, it results in observations vary due to the functional ability of individuals on any given day. It is expected that the successful bidder will reduce variation.

The assessment is conducted as an on-site (home) assessment allowing the assessor to visually assess the adequacy of the home environment as well as observation of the individual's strengths.

Question 61: Does the contractor need to be a licensed utilization review organization (URO)?

Response: No

Question 62: Is Medicare/Medicaid certification required to be considered as a contractor?

Response: No

Question 63: Is there a need for any NY State specific licenses, Certifications or other credentials (URAQ, NCQA, JCAHO) to be considered as a contractor?

Response: No

Question 64: Subcontracting - Page 200, Question O indicates no subcontracting is allowed without specific permission, yet the Women and Minority Business owner sections Page 50 E17 seems to indicate subcontracting. Is the contractor allowed to utilize subcontracted field assessors, most of whom are women?

Response: Subcontracting is not allowed without explicit permission from the Department. If the bidder proposes to utilize a minority or women's business enterprise as a subcontractor, the bidder should provide a full explanation of its intention in its proposal. Depending on the percent of effort to be provided by the subcontractor, the Department may require additional information from the bidder. All subcontractors of a successful bidder for a Component will be required to meet the same Vendor Responsibility standards and undergo the same Vendor Responsibility review as the prime contractor.

Question 65: What is the percentage of denied cases (preferably by program type) and how many go to Fair Hearing process?

Response: The Department does not maintain this information.

Question 66: What is the distribution of provider agencies for each program?

Response: It is unclear what is being requested and how it assists a bidder in preparing their proposal.

Question 67: The RFP requests the capability of providing necessary services with 24/7 availability. What services need to be provided on a 24/7 basis? Is it more than telephonic services? Is there a clinical component?

Response: The Assessment Center itself would not provide **direct** services on a 24/7 basis **but should have knowledge of any services that are available 24/7.**

Question 68: What is HRA's current role in this program and how does the contractor interact with HRA?

Response: Long Term Care Assessment Centers do not currently exist, therefore there is no answer to the first part of the question. Following contract execution it would be expected that the contractor would initiate and maintain communications with the local district with respect to necessary interactions.

Question 69: Does NYS have any studies showing how much time it takes to do the assessments and re-assessments, including travel time? What percentage are early re-assessments?

Response: The Department does not have studies identifying time involved in assessment/reassessments.

Question 70: Where can 80 ADMIN 9 and 83 ADM 74 be located? They are not listed at the resource listed in Attachment 20: <http://onlineresources.wnylc.net/pb/default.asp>

Response: These documents will be posted on the Department's web page at <http://www.nyhealth.gov/funding/rfp/0907070849/> for this RFP.

Question 71: What does it mean when the RFP stipulates that the contractor would be "Conducting home based nursing and social assessment jointly with LTHHCP"? Will the contractor be required to coordinate scheduling the on-site assessment so that a LTHHCP representative attends the assessment as well?

Response: The Assessment Center would coordinate with the LTHHCP to schedule the joint assessment visit.

Question 72: In terms of physician's [sic] orders, is it the expectation that the order from the physician will be to perform a nursing assessment, or will the physician be ordering the particular type of care setting and hours they feel are necessary? If it is the latter, are the physician's [sic.] on board with this new approach to provide more objective and consistent assessments or will the contractor be required to work with the physician to assure they will be in agreement with the most appropriate care setting?

Response: The purpose of the physicians' order and the information which must be included varies by Medicaid program/service; regulations and policy documents for each program area.

Question 73: If an applicant also operates a home care agency or other provider that would be served by the Assessment Center, is their a preferred method of separating the entities?

Response: The bidder must include their plan for preventing a conflict of interest where one might exist. See RFP Part D.3.b.VIII.

Question 74: Can an applicant share services (such as finance & HR) and executive leadership with a provider that would be served by the assessment center?

Response: Any such proposed sharing of services should be addressed in a bidder's conflict of interest statement (Attachment 11) including a description of the bidder's mechanisms, policies and protocols that would be established to avoid a conflict of interest.

Question 75: Specifically, what sections of the narrative have to be kept in the 30 page limit? Does the 30 page limit include any charts or forms requested in the instructions for those 30 pages, or would that be in addition to the 30 narrative pages? Would the state consider increasing the 30-page limit to 50 pages?

Response: Please see Part D.3.b.IV. page 20 of the RFP which states, "The narrative for Sections D.3.b.IV(A) through (F) must not exceed 30 pages in length, single spaced in a font no smaller than Times New Roman, 12". Charts and forms are considered to be outside of the 30 page limit. The Department will not consider increasing the 30 page limit.

Question 76: Attachment 24, Appendix D, General Specifications; Section L: In certain circumstances, the contractor might hold prior licenses with IT vendors for the use of applications software and source codes that it intends to employ in the demonstration project. Such licenses might prohibit the contractor from disclosing relevant information or allowing its use by third parties. In such circumstances, will the State make exceptions with respect to the requirement of Attachment 24, Appendix D, Section L, or special arrangements, to enable the contractor to remain in compliance with its prior IT vendor licenses?

Response: No. If the selected contractor is involved in such licensing arrangements, it will be the responsibility of the contractor to obtain amendments to its licensing or make other arrangements in order to meet the requirements of Section L.

Question 77: Attachment 23, Standard Clauses for NYS Contracts; Item 2, Non-Assignment Clause: What happens in the event that the contractor must enlist a new subcontractor or replace an old subcontractor following the start date of the Assessment Center? What happens if the contractor, prior to the award of the contract, has already subcontracted and/or leased goods, equipment, or services, including IT, that it intends to employ in the implementation of the demonstration project? Must the State approve these existing subcontractors and/or licenses?

Response: The State must generally approve all such arrangements. If a contractor proposes to use leased equipment or office space, for example, the Department would not require prior approval. However, if the contractor were to subcontract its obligations under the contract, then the Department would need to approve the contract in advance.

Question 78: Page 6, Section A: Will any permits/waivers from the federal government, such as an HHS "freedom of choice of provider" waiver for Medicaid clients, be needed? If so, who applies for and maintains these waivers?

Response: There are no known permits/waivers required from the federal government.

Question 79: Page 15, Section C.7: Subsequent to the demonstration project, will the contractor have a royalty-free license to use the applications software and new source codes developed during the RFP contract term?

Response: No. See Attachment 24, Part Z.

Question 80: Pages 32-33, Section D.5.b – D5.g: In lieu of the required documents, what would be expected from a city agency such as HRA were such an entity to bid on the contract?

Response: A governmental agency would need to provide the Vendor Responsibility Attestation.

Question 81: Page 48, Section E.14: If NYS becomes aware of an information security breach, will NYS notify the contractor immediately?

Response: Yes

Question 82: Attachment 10, Section 6: Is mutual indemnification possible?

Response: No.

Question 83: Attachment 26, Section VII (a): Is the contractor allowed to seek other remedies if there is a violation of the Business Associate agreement that causes irreparable harm to the contractor?

Response: The bidder does not need this information in order to develop a proposal under this RFP. However, it is noted that the HIPAA Business Associate Agreement details the State's rights in the event of a breach of that agreement by the contractor. The bidder will have to consult with its own attorney to determine whether it has any rights, independent of the State's right if the contractor breaches the HIPAA Business Associate Agreement.

Question 84: Attachment 27, Paragraph 1: Do assessments done by the State Assessment Center qualify as Medicaid Confidential Data?

Response: Yes.

Question 85: Attachment 27, Paragraph 3: Is the disclosure and unapproved use of Medicaid Confidential Data prohibited without the prior written permission of the contractor?

Response: Disclosure and unapproved use of Medicaid Confidential Data is prohibited. The Contractor cannot authorize the disclosure of Medicaid data.

Question 86: General - Is the contractor required to have an office within the region of the individuals being served?

Response: While the RFP does not specifically require the contractor to maintain an office within the respective region(s), a bidder should incorporate information about a local office presence and the effective operation of its proposed Assessment Center.

Question 87: Page 10 §B.8. CHHA - Is the contractor responsible for the review of services provided to Medicare and Medicaid patients who have exhausted their Medicare days of service or the prospective payment?

Response: The contractor is responsible for assessment review and authorization of services for each sixty day period following the initial sixty day period of CHHA Medicaid services.

Question 88: Page 23 §D.3.b.4.(F) - Can the tabular portion of the work plan be placed in the Supporting Documentation section?

Response: No.

Question 89: Page 28 §D.3.b.XI(B), (1st paragraph) –

- a. Under what circumstance could a contractor bill for direct services and administrative services?

Response: If by “direct services” the questioner means “Medicaid provider services” there are no circumstances under which the contractor could bill for both direct and administrative services. If by “direct services” the questioner means “Direct assessment services,” see Part D.3.b.XI. starting on page 27 of the RFP.

- b. Would a contractor that performs direct services be eligible to also conduct administrative case management for the same patient? Would this not be a conflict of interest?

Response: See the response to Question 87.a. above. There are no circumstances under which a provider billing for Medicaid services may also bill for administrative case management under this RFP related to those Medicaid services

- c. If the contractor is not a provider of LTC services, nor bills Medicaid on a case by case basis, could this happen?

Response: See Part D.3.b.XI. of the RFP, starting on page 27.

Question 90: Page 11 §C.2. (2nd paragraph) - Will DOH provide access to MMIS files for consumers denied services? If so, will a DUA be required between DOH and the contractor?

Response: Access (either directly or indirectly) to MMIS files for this purpose would be considered. The process and details associated with such access would need to be discussed with the selected contractor(s).

Question 91: Page 12 §C.2.b. PERS (1st bullet) - Does validation of services being received require the contractor to conduct unannounced visits to the consumer’s home?

Response: The contractor will be expected to verify that the consumer is receiving personal care aide or home health aide services prior to authorizing or reauthorizing PERS. Unannounced home visits are not a requirement for making this determination.

Question 92: Page 12 §C.2.a. PCSP §C.2.c. CDPAP (4th bullet) - Under what circumstances would consumers be reassessed every 12 months?

Response: The PERS regulations and implementing policy directive (91 ADM 42) limits the PERS authorization to six months.

Question 93: Pages 12-13 §C.2.a., c., d., e., f., h. - Who is responsible to request the physician order? The provider of LTC services or the contractor?

Response: Responsibility for obtaining physician orders varies by program. Regulatory and policy directives for each discrete program/service should be referenced.

Question 94: Pages 12-13 §C.2.a., b., c., d., e., f. - How will the contractor be notified that the consumer is still in the LTC program and requires a reassessment or when the consumers circumstances require a reassessment?

Response: The contractor will be expected to develop a process for assuring that under-care cases are reassessed at required intervals and when unexpected changes to the consumer's medical, mental or social circumstances occur that would affect the type, amount or frequency of services being provided. For the LTHHCP, the contractor will be expected to maintain a working relationship with the LTHHCP agency providing services to assure that the participant's reassessment (every 120 days or sooner if a significant health status change occurs) is completed in a timely manner to assure authorization of ongoing participation in the program.

Question 95: Page 13 §C.2.d. ALP - Will the contractor be responsible to validate RUGS II or RUGS III (if NYS implements) as part of the contract?

Response: The provider is responsible for determining whether to prior authorize Medicaid payment for services provided to a recipient participating in the Assisted Living Program (ALP). At the time of assessment and reassessment, the contractor must review the ALP's assessment and RUG category determination for the recipient and determine whether they are in agreement before prior authorizing payment to the ALP. The contractor has the option of conducting its own ALP assessment and RUG determination before making this decision. Contractors also have the option of developing post-prior authorization procedures to assure the validity of the ALP's RUGS determination and of services being provided to the recipient in accordance with assessed needs.

Question 96: Page 13 §C.2.e. LTHHCP (4th bullet) - The fourth bullet point in this section mentions the "approved expenditure cap." Please define the Medicaid cap and where it can be found.

Response: Participants of the LTHHCP are subject to an individual expenditure caps that are based on the average cost of nursing facility care in the county where the participant resides. Expenditure caps are calculated annually by the Department for each local district across the State. The contractor will be expected to determine the appropriate expenditure cap related to the assessed level of care determined by the DMS-1 and to calculate the participant's monthly budget based on the applicable expenditure cap. The expenditure caps are transmitted by letter to each local district and are posted to the Health Provider Network for LTHHCPs to access. The Department will transmit the same information to the contractor annually.

Question 97: Page 14 §C.4 - Can the State provide an estimate of the percent of decisions that require Fair Hearings/court appearances?

Response: The Department cannot produce that information.

Question 98: Pages 14-15 §C.5 Administration §C.8 Staffing - Section C.5. references the “Project Director,” but this position is not mentioned in C.8., which outlines minimum staffing. Is the “Project Director” the same as the “Project Manager” or are these two separate positions?

Response: Part C.8. should refer to the “Project Director.”

Question 99: Page 17 §C.10. Travel - Would the State consider honoring the Federal travel rates, which are consistent with the state rates?

Response: The bidder should present its cost estimates associated with travel as part of its bid.

Question 100: Page 20 §D.3.b.IV(A) Preferred Eligibility -

a. Does the Preferred Eligibility section require any narrative or only completion of Att. 9-Preferred Eligibility Form?

Response: Attachment 9 does not require any narrative.

b. Please explain the request to “Verify the information provided in the chart in responding to the questions in Part D.3.b.IV(D)”

Response: When responding to the questions in Part D.3.b.IV(D) the bidder must confirm by example and/or documentation in the appropriate location, the information provided in Attachment 9.

c. Can this information be included in the Supporting Documentation section?

Response: No.

Question 101: Page 25 §D.3.b.V. (5) (2nd bullet) - Please define “strength-based” and “task-based,” as they relate to this task.

Response: This RFP requests proposals from qualified bidders who are capable of performing a contract for the assessment services described. The Department assumes that all bidders have sufficient background and experience to understand the program requirements of the proposal.

Question 102: Page 27 §D.3.b.VIII (2nd paragraph) - May conflict of interest policies, which could be detailed, be included in the Supporting Documentation section?

Response: The copies of the policies must be included in the Technical Proposal, but are not part of the narrative.

Question 103: Page 28 §D.3.b.XI(B) - Regarding the last bullet and three sub-bullet points on page 28, is it the role of the contractor to *make arrangements regarding care or rather to coordinate activities* with the provider(s) of care?

Response: This Part requires the contractor to “assure that capability exists” for the listed activities.

Question 104: Page 29 D.3.b.XIII Travel - Would the state consider car service, in limited circumstances, for taking assessors to and from consumer homes to be “appropriate” for reimbursement?

Response: It is conceivable that car service might be “appropriate” transportation in some circumstances. Please refer to Question #99.

Question 105: Attachment 5. Line Item Bid Form - Should hourly prices requested in Parts II and IV be based on burdened rates, i.e., include fringe benefits and indirect costs?

Response: The hourly rates should include fringe but not indirect costs, as those should be covered in the administrative percentage.

Question 106: Attachment 18. Service Unit Volume Projection Charts - Attachment 18 is missing the annual assessment estimate for the Consumer Directed Personal Assistance Program (CDPAP). Will the State provide the missing information or provide guidance on pricing the program as a service unit without it?

Response: The revised Attachment 18 clarifies that the Personal Care Services Program estimates include CDPAP.

Question 107: Attachment 26. HIPAA Business Associate Agreement - Please confirm that Attachment. 26-HIPAA Business Associate Agreement is to be included in the proposal, or whether a statement assuring the contractor’s compliance is acceptable in lieu of the BAA. (The form requires no signature or bidder information.)

Response: A statement assuring the contractor’s compliance is acceptable. The form will be added as an Appendix to any contract awarded under this RFP.

Question 108: Attachment 29. Bidder’s Checklist - The Checklist says to include eight attachments in the Technical Proposal (i.e., 6, 7, 8, 9, 10, 11, 26 and 27). Will any of these completed attachments/forms be counted against the 30-page limit?

Response: No.

Question 109: If a consumer has been referred for assessment of need for personal care services and the Assessment Center determines the individual to be ineligible on the basis that personal care or CDPAP would not adequately meet the consumer’s needs, will the contractor assess whether that consumer is eligible for, and could be appropriately served by, another program or service that falls under the aegis of the Assessment Center?

Response: In such instances the Assessment Center would be expected to advise the consumer of other programs/services for which they may qualify and can be delivered in a manner promoting the health and safety of the consumer.

Question 110: Is the contractor expected to have a mechanism for authorizing services in emergency cases? If yes, what are the contractor’s liabilities in such instances?

Response: Given the nature of the programs and services falling under the aegis of an Assessment Center, we are unclear of cases that would be defined as emergency in nature. An Assessment Center is expected to be responsive to timelines for assessment/authorization as specified in regulation.

Question 111: In the case of ongoing assessment of need for CHHA services beyond 60 days, if the contractor determines that continuation of CHHA services is not warranted, is the contractor

required to assess the individual for other services that fall under the Assessment Center's authority? Would a discontinuation of or change in CHHA services require a Notice of Decision and trigger Fair Hearing rights?

Response: The Assessment Center will be expected to advise the consumer of other programs/services for which they may qualify. A discontinuation of or change in CHHA services would require a Notice of Decision and trigger Fair Hearing rights.