

Enrollment Broker Services Request for Proposals (RFP #1102040410)
AMENDMENT #1
April 20, 2011

NOTE: Questions related to this amendment **ONLY** will be taken until 5:00pm Tuesday, April 26, 2011. Answers to these questions will be posted on the Department website on or about April 28, 2011. Please submit questions to Cherlyn More at cbm01@health.state.ny.us.

To implement changes made to State statute to support reform activities of the Medicaid Redesign Team, pending Centers for Medicare and Medicaid Services (CMS) approval, the following are official modifications, which are hereby incorporated into the New York State Department of Health, Office of Health Insurance Programs Enrollment Broker Services Request for Proposals (RFP), issued March 23, 2011. The information contained in this amendment prevails over the original RFP language. Deleted language appears in strikethrough [--] and added language appears in underline [___].

Revision #1

Section C.2.1 Mailings to Consumers, pages 9-12, is amended to read as follows:

~~Using Medicaid eligibility information supplied by the Department, the Contractor shall conduct a targeted mailing to mandated populations. Mailings are required to be generated to existing Medicaid recipients and to new and existing SSI cash individuals who are not exempt or excluded from enrollment. The enrollment broker shall generate a mailing from when there is a change in status in the eligibility updates received from the Department, and must accomplish the mailings within five business days of initial receipt of information from the State. If for some reason the Contractor cannot meet the five day timeframe, they must notify the Department. Mailings shall not include new applicants for Medicaid as it is expected those individuals known to be exempt or excluded will choose a plan at time of application.~~

Enrollment forms printed with the household information, including case members shall be included in the mailings, however, exempt or excluded individuals shall not have their name and personal information printed on the enrollment forms included in the routine mailings. At a minimum, these initial mailings are generated per household and must contain a cover letter that identifies eligible consumers; mandatory brochure; health plan list; pre-printed enrollment form; a consumer guide for choosing plans (currently produced and supplied by the Department) and business reply envelope. A full list of materials is located in section C.2.4 of the RFP.

~~Thirty (30) days after the initial mailing, Contractor shall mail a second notification that includes a cover letter, enrollment form, and business reply envelope to each Medicaid Consumer who has not enrolled or made a choice of managed care plan.~~

~~Forty five (45) days after the initial mailing, Contractor shall mail a third notification encouraging a choice of managed care plan to each Medicaid Consumer who has not enrolled or made a choice of managed care plan, and to whom the second notification has been mailed. This shall include a cover letter, enrollment form, and business reply envelope. The Contractor shall have the ability to run the auto-assignment algorithm at the time of the generation of the 45-day letter, and include the name of the potential assignment plan in that mailing.~~

The Contractor must have systems in place that can track and generate or prompt the generation of all appropriate mailings.

The ~~broker~~ Contractor is expected to have staff on site at each of the LDSS offices (unless waived by the Department) and other locations designated by the Department to provide in person education about managed care to consumers who are at the district office for an interview, application assistance, or other LDSS business. During the educational session, consumers are informed that they live in a mandatory county, and if not eligible for an exemption or exclusion, must enroll in a managed care plan. ~~Eligible consumers~~ Consumers eligible for enrollment are told which managed care plans are available in the county and that they can enroll during the session. ~~or if they do not choose a plan at that time, a mailing will be sent to them advising that they will have to choose a health plan or one will be chosen for them.~~ Consumers should be informed that if they are applying for Medicaid or Temporary Assistance and do not choose a plan at this time, they will be auto-assigned upon case opening. If they are current Medicaid recipients, and do not choose a plan, they will receive a mailer advising them to choose a plan or they will be auto assigned.

~~Mailings are necessary for those who do not choose a plan at the time of their renewal, or do not come into the LDSS for their Temporary Assistance (TA) renewal, and for all new Medicaid cases eligible for managed care. If situations arise that do not allow the Contractor to make in person presentations to consumers during renewal or application, the Contractor will mail to those consumers.~~

Effective April 1, 2010, the requirement for Medicaid and Family Health Plus applicants to have a face-to-face interview was discontinued. However, application assistance must be provided when requested by the consumer. The Contractor will be expected to work with the Department, or its designee, to determine the most efficient way to meet with Medicaid/FHPlus applicants who appear at the agency for application assistance (to submit required documentation, have important documents copied, or fulfill other requirements). The Contractor will also be expected to develop other ways to outreach to applicants in order to educate and enroll; such ways may be unique to each LDSS. The Department may add other mailings to specified populations as needed.

The Contractor must make mailing files or other documentation of mailings available to the Department for monitoring purposes in accordance with reasonable specifications and timeframes as requested by the Department.

In general the Contractor must be flexible to meet the needs of the Department in conducting mailings to increase enrollment, such as using processes outside of the routine mailings to capture pockets of unenrolled consumers.

Revision #2

Section C.2.2.4 Facilitated Enrollment Process, first paragraph, page 13, is amended to read as follows:

The Contractor must be capable of processing managed care enrollments that are submitted by Facilitated Enrollers, to the extent that Facilitated Enrollment is permitted by state statute. Facilitated Enrollers are entities contracted by the Department (e.g., community-based organizations and health plans) to assist individuals in applying for insurance coverage. Most individuals may must choose a managed care plan at the time they apply for Medicaid and Temporary Assistance, unless they are eligible for an exemption or exclusion, or they will be auto assigned to a plan when eligibility is

established. Individuals must also choose a managed care plan for Family Health Plus or the application is considered incomplete, unless there is only one plan to choose from, under which circumstance, the consumer does not have to make a choice.

The Contractor must be capable of accepting and pending ~~that~~ enrollments until Medicaid eligibility is finalized. This may be the current Medicaid program where the consumer has chosen a managed care plan, or the Family Health Plus program. When eligibility is established, and that data becomes available to the Contractor through the daily file update from the State, or through the Facilitated Enroller, the Contractor shall immediately process that managed care enrollment. The Contractor must also be able to prevent mandatory or voluntary mailings to newly eligible Medicaid or Family Health Plus consumers who have facilitated managed care enrollments pending eligibility.

Revision #3

Section C.2.2.6 Auto Assignment, page 16, is amended to read as follows:

The Contractor shall assign a health plan to a Medicaid consumer who does not enroll in or choose a managed care plan ~~within sixty (60) days of the initial mailing for non-SSI recipients at the time of new application or within ninety (90) days of the initial mailing for SSI recipients in accordance with the Department's assignment algorithm. Persons living with HIV/AIDS may have up to 90 days to choose a plan. If they receive a notice advising them that they must enroll in 60 days, they may call the Contractor and ask for an additional 30 days. If they—~~ thirty (30) days for new SSI cash cases and current Medicaid recipients that do not choose a plan— after the initial and only mailing. Persons living with HIV /AIDS who do not choose a plan are auto assigned to a mainstream plan.

New applicants (as defined by the Department) will be identified in the daily eligibility update file received from the Department. If the consumer meets the definition of a new applicant and did not choose a managed care plan at the time of application, his/her record will be pended. The Contractor will check the update file for an enrollment. If after 10 days there is still no enrollment the individual will be auto-assigned based on monthly roster pulldown and an enrollment confirmation notice sent. This notification must indicate the managed care plan assignment, the time frame prior to lock in, and instructions on how to change managed care plans.

The auto-assignment algorithm takes into account many factors including where the consumer lives, plan service areas, past enrollment in a plan, and preferences for certain plans based on quality factors and whether the plan is a provider-sponsored plan. The Contractor must ensure that beneficiaries are not auto-assigned when exempt or excluded from enrollment, or when they should not be assigned for some other reason such as when an exemption or exclusion request is still in the review process, or a fair hearing decision is pending and affects the enrollment status. A more complete discussion of the auto-assignment process can be found in the Procurement Library.

The Contractor shall then electronically notify the managed care plans within three (3) days of those Medicaid consumers that have been auto-assigned to those managed care plans. The Contractor shall also mail to each Medicaid consumer who has been properly notified but who has not enrolled or made a choice of managed care plan within the allotted time, a notification announcing the automatic assignment. This notification must indicate the managed care plan assignment, the time frame prior to lock in, and instructions on how to change managed care plans.

~~The current process names the auto-assigned plan in the second reminder letter at 45 days after the initial mailing. The final assignment letter then confirms the enrollment if no plan is chosen after 60 days for non-SSI recipients or 90 days for SSI recipients.~~

Revision #4

Section C.2.4.1 Outreach, Education and Enrollment Materials, sub-paragraph B, pages 21-22, is amended to read as follows:

B. Other materials necessary for the program mailings include:

- ~~• Two enrollment reminder letters, one additional for SSI and SSI Related consumers~~
- ~~• Auto-assignment notices~~
- Enrollment confirmation letters
- Enrollment denial letters
- Health assessment forms
- Exemption applications
- Exemption approval and denial notices
- Fair hearing notices
- Disenrollment forms
- Disenrollment confirmation notices, including reason for disenrollment
- Incomplete exemption or enrollment letters
- Reminder letters for incomplete exemption applications
- End of lock-in notices
- Other ad-hoc notices as directed and approved by the Department

Revision #5

Section C.4 Managed Long Term Care, pages 34-35, is amended to read as follows:

Currently, enrollment in a Managed Long Term Care Plan (MLTCP) is accomplished through the following process:

- The MLTCP conducts the clinical assessment of the potential enrollee using the Semi Annual Assessment of Member (SAAM); determines the potential enrollee meets programmatic eligibility criteria (age, residency, etc.); develops a plan of care for enrollee. Enrollee signs Enrollment Agreement.
- Enrollment package sent to LDSS. LDSS reviews documentation to verify Nursing Home (NH) eligibility level of care and that beneficiary meets all other enrollment criteria. Any questions due to incomplete/inconsistent material are sent back to the MLTCP for resolution.
- The LDSS determines the enrollee spenddown and informs Medicaid eligible applicant and plan of spenddown amount. The MLTCP collects the spenddown.
- If enrollee application is acceptable, LDSS approves; inputs information to PCP subsystem and changes coverage code; sends notice to enrollee.

- If LDSS disagrees with enrollment, application is discussed with MLTCP; if not resolved, move to dispute resolution process.
- If MLTCP denies enrollment, LDSS must concur with denial; if concur, sends notice to applicant; if LDSS does not concur, discuss with MLTCP; if not resolved, move to dispute resolution process.
- If enrollee is permanently placed in a nursing home, the LDSS determines institutional eligibility for full Medicaid coverage; determine the amount of the enrollee's net allowable monthly income (NAMI); notify plan of the amount of the NAMI to be collected. (The NAMI amount is the portion of the recipient's monthly income which must be applied toward the cost of care.)
- If MLTCP proposes to involuntarily disenroll an enrollee, MLTCP provides LDSS with supporting documentation. LDSS must concur or disagree with disenrollment based on review; if concur, sends disenrollment and fair hearing notices to enrollee; if LDSS does not concur, discuss with MLTCP; if not resolved, move to dispute resolution process.
- In NYC Managed Long Term Care program enrollments, disenrollments and transfer requests are submitted to the Contractor by the LDSS. The Contractor generates all appropriate enrollment, disenrollment and transfer notices to the consumer.

Current enrollment criteria in a Managed Long Term Care Plan is as follows:

- Certified as Nursing Home Level of Care, derived from Semi Annual Assessment of Member;
- In need of the community based long term care services of the plan for more than 120 days;
- Able to live safely in the community with the services of the plan, based on criteria developed by the State;
- Live in the service area of the plan;
- Age requirement varies by plan: 18, 55, or 65 and older;
- Payment source varies by plan: Dual Eligibles, Non Duals, some plans accept private pay.

Bidders must include in their proposed approach a description of how they would provide the following services ~~in all counties in the event the Department in its sole discretion opts to include MLTC enrollment functions in the contract resulting from this RFP~~ to support the Managed Long Term Care program effective October 1, 2011.

- ~~Verify enrollee's clinical and programmatic eligibility through review of the Semi Annual Assessment of Members (SAAM) assessment score or successor uniform assessment tool; review SAAM annual assessments. -~~ In NYC, receive and process MLTCP program enrollments, disenrollments and transfer requests received from plans and send appropriate notices to consumers. These costs should be included in the per unit cost for enrollment application processing. This activity may be expanded to additional counties.
- ~~Review materials submitted by plans to justify continued enrollment when the member no longer meets nursing home level of care criteria as indicated by the SAAM score. Continued enrollment assessments are conducted during the second half of the year (or in the anniversary~~

~~month of enrollment for PACE). Plan must justify that the enrollee would likely be nursing home eligible again within 6 months without the plan's services for the member to remain enrolled.~~

- Develop and implement a process for review/processing of denial of enrollments, and involuntary disenrollments to be used in all counties throughout the State. Issue Denial of Enrollment Notices, and Fair Hearing Notices (including Fair Hearing notices specific to MLTC).
- Develop a dispute resolution process regarding denial of enrollment/disenrollment decisions with plans. Denials will be based on not meeting Nursing Home Level of Care, Health and Safety, and not meeting the 120 day requirement. If MLTCP proposes to involuntarily disenroll an enrollee, MLTCP provides the Contractor with supporting documentation. The Contractor will concur or disagree with disenrollment based on review; if the Contractor concurs, the Contractor sends disenrollment and fair hearing notices to enrollee; if Contractor does not concur, discusses with MLTCP; if not resolved, move to dispute resolution process where the Contractor confers with a third party to be determined by the Department for final resolution. These costs should be included in the per unit cost for enrollment transactions.
- Attend Fair Hearings to defend decisions about denials and involuntary disenrollments.

~~Until mandatory enrollment is implemented, the expected monthly volume of MLTC applications is between 900 – 1500 per month under the voluntary enrollment program. This volume is not guaranteed and actual volume will fluctuate over the term of the agreement. Bidders should identify the costs associated with these responsibilities separately in the Cost Proposal. The technical aspect of this component is incorporated into the broker technical proposal. The cost proposal requires the bidder to develop separate costs for the MLTC component of this RFP. Involuntary disenrollments average approximately 70 per month and denial of enrollments range between 5 – 10 per month.~~

~~The State reserves the right to include or exclude the MLTC component based on the availability of funds to support this component and the submission of a proposal by a bidder with the ability to fulfill the responsibilities related to this component based on the information in this RFP.~~

Mandatory Managed Long Term Care

To implement changes made to State statute to support reform activities of the Medicaid Redesign Team, the State will require the transition and enrollment of people who meet the following criteria into Managed Long Term Care (MLTC) plans or other care coordination models approved by the Commissioner of Health effective April 1, 2012:

- Age 21 and older;
- Eligible for Medicare and Medicaid; and
- In need of community-based long term care services for more than 120 days.

Three models of MLTC now operate in New York – the Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus (MAP) and partially-capitated plans. Partially capitated plans are expected to be the primary type of plan these individuals will enroll in because there is no requirement

for concurrent Medicare enrollment. However, where available and when additional plan-specific enrollment criteria are met, people will have an option to select PACE or MAP as well.

Pending CMS approval mandatory enrollment will begin April 1, 2012 in New York City, where MLTC capacity is adequate, individuals who need community based long term care services for more than 120 days will be required to enroll in MLTC plans or other care coordination models specified by the Commissioner of Health. Those who must enroll would include those currently served in community based long term care programs as well as people who are new to long term care. Non-dually eligible disabled adults who meet these criteria will have the option of joining a MLTCP in lieu of an MMC plan.

Mandatory enrollment will expand throughout the rest of the State as MLTC plans or other care coordinated models become available. People who are in the Assisted Living Program, Nursing Home Transition and Diversion waiver, Traumatic Brain Injury waiver and those served through the Office of People with Developmental Disabilities would be exempted from mandatory enrollment in a MLTC program until the State develops appropriate program features for these populations.

Partially capitated plans will expand their current target population beyond those who are nursing home eligible to include all dually-eligible people in need of long-term community based services. Necessary changes will be made to permit Consumer Directed Personal Assistance Program services to be made available through the MLTC plans.

New York City has the greatest concentration of plans and members at present. Ten partially capitated plans serve approximately 27,000 members, 7 MAPs serve 450, and 2 PACEs serve 2,400.

Mandatory enrollment is anticipated to begin in New York City and be phased-in throughout the rest of the State as plan capacity is developed. Dual eligibles who are current users of community Long Term Care Services will be provided a notice before reassessment that they have 30 days to choose a plan and will be provided with information and assistance about specific plans in their service area. This information will include a description of the types of plans and programs available, to promote an informed choice. As with the mainstream managed care the Contractor will assist in the development, production and distribution of these materials and should include these costs with mainstream costs.

If the individual does not make a choice, he/she will be auto-assigned to a partially capitated plan. The Contractor will be responsible for auto assigning these individuals. It is expected that approximately 2,000 people per month will transition to MLTC or other care coordination models during a 36 month phase-in period. Enrollees will have the ability to disenroll from one plan and join another if dissatisfied. New Medicaid Applicants who are also in need of community based long term care will be provided with similar information and have a choice of the types of plans and programs available. If they do not make a choice, they will be auto-assigned to a partially capitated program.

Prior to implementation of mandatory MLTC enrollment, the Department will utilize the Enrollment Broker to improve consumer knowledge and understanding about MLTC toward increased voluntary enrollment as well as to streamline the administrative process for joining a plan. All MLTCPs must currently provide interested parties with information about the plan, such as member handbooks and provider network listing. These requirements are now in place to ensure informed choice and the voluntary nature of enrollment.

Bidders must include in their proposed approach a description of how they would provide support for the mandatory MLTC initiative. Implementation will mirror processes utilized in mainstream managed care. The MLTC population is included in the proposed volumes in the cost proposal. Costs for these activities should be included in with costs for the mainstream program.

Revision #6

Section C.5 Performance Measures, Outreach and Education Activities, bullet 1, is amended to read as follows:

- Monthly auto-assignment rate is below 30% for NYC and 30% for all Non NYC local districts served. Rates will be calculated separately for NYC and for all other local districts served. The Department may waive or modify this measure during the contract period.

Revision #7

Section D.2.4.2.1 Mailings, sub-section C, pages 42-43, is amended to read as follows:

- C. In accordance with the mailing schedule described in Section C.2.1, explain how the bidder will mail to each Medicaid Consumer who has not enrolled or made a choice of managed care plan within 30 days of the bidder's initial mailing, ~~a second notification that the Consumer is being assigned to a plan and which plan.~~ Describe how the bidder will mail to each newly eligible Medicaid Consumer who has not enrolled or made a choice of managed care plan ~~within 45 days of the initial mailing, and to whom the second a notification has been mailed, a third notification encouraging the consumer advising the Consumer that he/she is being auto assigned to choose a managed care health plan and which plan.~~

Revision #8

Section D.2.4.2.7.A, page 48, is amended to read as follows:

- A. Submit ~~include~~ job descriptions and qualifications for each key staff position identified in Section C.3.1. Submit current resumes (including two references) for any staff members currently employed in these positions. Identify bilingual or multilingual staff and the languages that they speak. For any positions where an individual is not currently employed, resumes for those hired must be submitted to the Department for review prior to commencement of the contract and key staff must be approved by the Department. Key staff members are identified as those positions listed in C.3.1.

Revision #9

Section D.2.4.2.10 Managed Long Term Care (MLTC), page 50, is amended to read as follows:

- A. ~~Describe the bidder's process for reviewing the SAAM and other documentation upon initial application for the program and for reviewing plan requests for continued enrollment when the member no longer scores as nursing home eligible. Include in the description the staff responsible for reviewing the eligibility documents (SAAM), their experience and the training that will be provided to staff. Describe the bidder's process for reviewing denials and requests for involuntary disenrollments. Include in the description the staff responsible for reviewing documents provided by the MLTC to support their request, their experience and the training that will be provided to staff. Include in the discussion a description of how the bidder will ensure that appropriate notices will be sent including fair hearing notices when appropriate.~~

~~B. Describe the bidder's process for reviewing denials and requests for involuntary disenrollments and the dispute resolution process for resolving enrollment/disenrollment issues with plans. Include in the discussion a description of how the bidder will ensure that appropriate notices will be sent including fair hearing notices when appropriate. Describe the bidder's dispute resolution process for resolving enrollment/disenrollment issues with plans about denials and involuntary disenrollments.~~

Revision #10

Section D.3.3.7 Optional Activities – Pricing is Required, page 55, is DELETED.

Costs associated with MLTC activities should be included with costs for the mainstream program.

Revision #11

Attachment 2 BID FORM, pages 71-73, is replaced with Attachment 2 on the following pages.

Attachment 2 has been amended to delete pricing associated with the Section D.3.3.7 “Optional Activities – Pricing is Required”, deleted in Revision #10 above.

Attachment 2 -- REVISED

**NEW YORK STATE
DEPARTMENT OF HEALTH**

BID FORM

PROCUREMENT TITLE: Enrollment Broker Services

RFP #1102040410

Bidder Name: _____

Bidder Address: _____

Bidder Fed ID No: _____

A. _____ bids the following:
(Name of Offerer/Bidder)

Offeror's Bid on Program Areas – Cost Worksheet	
<u>D.3.3.1 Number of Mailings Completed</u>	Per Unit Price
Up to 25,000 mailings per month	\$ _____ per voluntary/mandatory initial mailing
25,001 to 60,000 mailings per month	\$ _____ per voluntary/mandatory initial mailing
Over 60,000 mailings per month	\$ _____ per voluntary/mandatory initial mailing
<u>D.3.3.2 Monthly Enrollment Applications Processed</u>	Per Unit Price
Up to 60,000 enrollment applications processed per month	\$ _____ per enrollment application processed
60,001 to 100,000 enrollment applications processed per month	\$ _____ per enrollment application processed
Over 100,000 enrollment application processed per month	\$ _____ per enrollment application processed
<u>D.3.3.3 HelpLine Activities</u>	Per Unit Price
Up to 75,000 calls per month	\$ _____ per call
75,001 to 150,000 calls per month	\$ _____ per call
Over 150,000 calls per month	\$ _____ per call
<u>D.3.3.4 Outreach/Field Staffing</u>	Cost
Baseline staffing of 40 FTE	\$ _____ per month
Each additional FTE above or below the baseline	\$ _____ per FTE per month
<u>D.3.3.5 Systems, Reporting and QA Staffing</u>	Cost
Baseline staffing of 18 FTE	\$ _____ per month
Each additional FTE above or below the baseline	\$ _____ per FTE per month
<u>D.3.3.6 Additional Costs – remains constant for full term of contract, including renewals</u>	
Additional Cost Fee %	_____ % on all approved additional costs

