Request for Proposals

RFP #20374

Independent Evaluation of New York State Health Insurance and Waiver Programs

Issued: January 11th, 2024

DESIGNATED CONTACT:

Pursuant to State Finance Law §§ 139-j and 139-k, the New York State Department of Health (hereinafter referred to as the "**Department"** or as "**DOH")** identifies the following designated person to whom all communications attempting to influence the Department's conduct or decision regarding this procurement must be made.

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New York State Department of Health
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PERMISSIBLE SUBJECT MATTER CONTACT:

Pursuant to State Finance Law § 139-j(3)(a), the Department ^ identifies the following allowable person to contact for communications related to the submission of written bids, written questions, pre-bid questions, and debriefings.

Andrew Lynch
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1.0 CALENDAR OF EVENTS

RFP (20374 – INDEPENDENT EVALUATIONS OF NEW YORK STATE HEALTH INSURANCE AND WAIVER PROGRAMS)	
EVENT	**DATE**
Issuance of Request for Proposals	January 11, 2024
Deadline for Submission of Written Questions	Questions Due by January 25, 2024 by 4:00 p.m. ET
Responses to Written Questions Posted by DOH	**On or About** February 8, 2024
Deadline for Submission of Proposals	Proposals Due on Or Before February 26, 2024 at **4:00 p.m. ET**
Anticipated Contract Start Date	January 1, 2025

2.0 OVERVIEW

Through this Request for Proposals ("RFP"), the New York State ("State") Department of Health ("DOH") is seeking competitive proposals from qualified proposers to provide services as further detailed in Section 4.0 (Scope of Work). It is the Department's intent to award one (1) contract from this procurement.

2.1 Introductory Background

The New York State (NYS) Department of Health receives federal funding from the Centers for Medicare and Medicaid Services (CMS) for certain activities, or demonstrations. The terms and conditions of these demonstrations require independent evaluations as a condition for initial and continued funding. These independent evaluations are also used by the Department staff to inform policies and oversight of public health insurance programs administered by DOH.

Below are the active and known upcoming independent evaluations required by the CMS that the independent evaluator would support. The independent evaluator would also support any new independent evaluations requested or required by DOH or the CMS.

1115 Waiver Demonstration

In July 1997, NYS received approval from the CMS through an 1115 Waiver, to implement a mandatory Medicaid managed care (MMC) program. The program, entitled the Partnership Plan Demonstration, set out to improve the health status of low-income New Yorkers by: 1) improving access to health care for the Medicaid population; 2) improving the quality of health services delivered; 3) expanding access to family planning services; and 4) expanding coverage to additional low-income New Yorkers with resources generated through managed care efficiencies. The primary purpose of the Demonstration was to enroll a majority of the State's Medicaid population into managed care, and to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who would otherwise be without health insurance. Initially, mandatory enrollment was limited to the Temporary Assistance for Needy Families (TANF) and Safety Net Populations. Over the past 20 years, more Medicaid populations were included in the Partnership Plan Demonstration, including those living with HIV/AIDS, supplemental security income, and certain populations in need of long-term care services and

supports (LTSS). The Partnership Plan Demonstration was originally authorized for a five (5)-year period and has been extended with amendments several times.

In March 2021, the Section 1115 Demonstration was temporary extended for one (1) year. As of the date of this RFP, the State is awaiting CMS approval for a three (3)-year renewal from April 2022 to March 2025, or the date of CMS approval.

1915(c) Children's Waiver

The 1915(c) Children's Waiver demonstration has the goal to streamline the children's Home and Community Based Services (HCBS) administration to have more consistent eligibility processes and benefits across all populations. In addition, this waiver provides a single HCBS benefit package to children meeting institutional level of care (LOC) functional criteria. Over a three-year period, eliminate the use of waiting lists related to HCBS capacity under the waiver. All of the HCBS services authorized under the six current 1915(c) children's waivers will continue to be authorized as either an HCBS authorized under the 1915(c) Children's Waiver or a new State Plan service. Provide Health Home care management to children eligible for HCBS and an administrative alternative for children that may opt of Health Home.

2.2 Important Information

The Bidder **must** review, and is requested to have its legal counsel review, Attachment 8, the DOH Agreement (Standard Contract), as the successful Bidder must be willing to enter into the Contract awarded pursuant to this RFP in the terms of Attachment 8, **subject only to any amendments to the Standard Contract agreed by the Department during the Question and Answer Phase of this RFP (**see, Section 5.2**)**. Please note that this RFP and the awarded Bidder's Bid will become part of the Contract as Appendix B and C, respectively.

It should be noted that Appendix A of Attachment 8, "Standard Clauses for New York State Contracts", contains important information, terms and conditions related to the Contract to be entered into as a result of this RFP and **will be incorporated, without change or amendment**, into the Contract entered into between DOH and the successful Bidder. By submitting a response to this RFP, the Bidder agrees to comply with all the provisions of the Contract, including all of the provisions of Appendix A.

Note, Attachment 7**,** the Bidder's Certified Statements, **must** be submitted by each Bidder and includes a statement that the Bidder accepts, **without any added conditions, qualifications or exceptions,** the contract terms and conditions contained in this RFP including any exhibits and attachments, including, without limitation, Attachment 8. It also includes a statement that the Bidder acknowledges that, should any alternative proposals or extraneous terms be submitted with its Bid, such alternate proposals or extraneous terms will not be evaluated by the DOH.

Any qualifications or exceptions proposed by a Bidder to this RFP should be submitted in writing using the process set forth in Section 5.2 (Questions) of this RFP prior to the deadline for submission of written questions indicated in Section 1 of this RFP. (Calendar of Events). Any such qualifications or exceptions that are not proposed prior to the deadline for the submission of written questions will not be considered by DOH after contract award. Any amendments DOH makes to the RFP as a result of questions and answers will be publicized on the DOH web site and will be available and applicable to all Bidders equally.

2.3 Term of the Agreement

The term of the Contract that will be entered into between the Department and the successful Bidder pursuant to this RFP will be for a period of five (5) years commencing on the date shown on the Calendar of Events in Section 1, subject to the availability of sufficient funding, successful Contractor performance, and approvals from the New York State Attorney General (AG) and the Office of the State Comptroller (OSC).

3.0 BIDDERS' QUALIFICATIONS TO PROPOSE

3.1 Minimum Qualifications

DOH will accept proposals from organizations with the following types and levels of experience and qualifications as a prime contractor.

- A minimum of three (3) years of experience conducting large-scale (at least one [1] million lives), multi-year program evaluations, including completion of at least one (1) such evaluation;
- A minimum of three (3) years of experience performing statistical analyses using claims and encounter data;
- A minimum of three (3) years of experience performing each of the following:
    - Statewide or CMS designated Medicaid region comparisons;
    - Longitudinal evaluations; and
    - Collecting and analyzing qualitative and quantitative data.
- At the time of bid, the bidder and any proposed subcontractor(s) must attest to not having any direct business relationship with any Medicaid MCO:
    - Medicaid Managed Care (MMC);
    - Health and recovery Plans (HARP);
    - Human Immunodeficiency Virus Special Needs Plans (HIV SNP);
    - Medicaid Long Term Care Plan (MLTCP);
    - Medicaid Advantage Plan (MAP);
    - Program of All-inclusive Care for the Elderly (PACE); and,
    - Self-Directed Care (SDC) pilot site agencies.

Experience acquired concurrently is considered acceptable.

For the purposes of this RFP, a prime contractor is defined as one who has the contract with the owner of a project or job and has full responsibility for its completion. A prime contractor undertakes to perform a complete contract and may employ (and manage) one or more subcontractors to carry out specific parts of the contract. However, a prime contractor may not leverage the experience of a planned subcontractor in order to meet the Minimum Qualifications identified above.

Failure to meet these Minimum Qualifications will result in a proposal being found non-responsive and eliminated from consideration.

4.0 SCOPE OF WORK

This Section describes the independent evaluation services that are required to be provided by the selected bidder. The selected bidder must be able to provide all of these services throughout the contract term.

PLEASE NOTE: Bidders will be requested to provide responses that address all of the requirements of this RFP as part of its Technical Proposal.

The terms "bidders", "vendors" and "proposers" are also used interchangeably. For purposes of this RFP, the use of the terms "shall", "must" and "will" are used interchangeably when describing the Contractor's/Bidder's duties.

The purpose of this RFP is to seek proposals from responsible and qualified Contractors to conduct comprehensive, statewide independent evaluations in accordance with the management and administration of the NYS Medicaid program. This includes but is not limited to independent evaluation work associated with the 1115 and 1915c waiver and other CMS or State required evaluations.

The prime contractor and any subcontractor(s) utilized must continue to refrain from any direct business relationship with Medicaid MCOs and SDC pilot site agencies for the duration of the contract.

The most recent New York State Special Terms and Conditions (STC) is valid April 1, 2022 and can be found at the following link: https://www.health.ny.gov/health_care/managed_care/appextension/2022-04-01_ny_stc.pdf

To view additional STCs, please visit https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm.
PLEASE NOTE: Bidders will be requested to provide responses that address all of the requirements of this RFP as part of its Technical Proposal.

The terms "bidders", "vendors" and "proposers" are also used interchangeably. For purposes of this RFP, the use of the terms "shall", "must" and "will" are used interchangeably when describing the Contractor's/Bidder's duties.

4.1 Tasks/Deliverables

A. Independent Evaluation for Medicaid Waivers and Other Federal Authorities

The Contractor will be responsible for independent evaluations for the following programs:

WAIVER	PROGRAM	Estimated Effort Over Five Years in Hours	POPULATION
1115	Medicaid Managed Care		Adults 19-64 years of age who are not eligible for Medicare, Children 1 - 18 years of age, Infants (under age 1), Pregnant Individuals, Parents and Caretaker Relatives of any age, who may have Medicare, Individuals 65 years of age and older, who are not a parent or caretaker relative, Individuals who are blind or disabled who do not meet the criteria of any of the above MAGI eligibility groups, including those individuals with an immediate need for Personal Care Services (PCS) or Consumer Directed Personal Assistance Services (CDPAS), Residents of Adult Homes run by LDSS, OMH, Residential Care Centers/Community Residences, and Individuals eligible for the following programs: o Medicare Savings Program (MSP), o COBRA, o AIDS Health Insurance Program (AHIP), and o Medicaid Buy-in Program for Working People with Disabilities Foster care and former foster care youth Individuals screened for Presumptive Eligibility (PE) with a provider
1115	Health and Recovery Plan (HARP)		Medicaid eligible adults with significant behavioral health needs Evaluation Plan (within RFP) – https://www.health.ny.gov/funding/rfp/20024/20024.pdf Evaluation Report- https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/docs/harp_interim_eval.pdf
1115	Self-Directed Care (SMC)		Medicaid eligible adults with significant behavioral health needs and deemed eligible for participation in a HARP
1115	Managed Long-Term Care (MLTC)		Are dual eligible (eligible for both Medicaid and Medicare) and over 21 years of age and need community based long-term care services for more than 120 days.

1115	HIV Special Needs Plans (SNPS)		Medicaid eligible Adults living with HIV/AIDS or are homeless or are transgender and their dependent children
1915c	Nursing Home Transition and Diversion (NHTD)		Adults eligible for community-based Medicaid, assessed as needing nursing home level of care, and either between the ages of 18-64 and have a verified physical disability or are age 65 or older when applying to the program.
1915c	Children's Waiver		Children meeting behavioral health or abuse and neglect targeting criteria, including children with complex trauma. All children in these target populations are at risk of institutionalization and meet risk factors and needs-based criteria but do not meet institutional LOC.
1915c	Traumatic Brain Injury (TBI) Waiver		Adults between the ages of 18-64, enrolled in Medicaid, diagnosed with TBI who require nursing facility level of care as a result of their TBI.
CMS 438.6c	Individual State Directed Payment models		Delivery system and Provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments) that require a Section 438.6c preprint, evaluation plan, and evaluation. There are currently 14 in New York, with more expected. Preprint- https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html

B. Independent Evaluation Components

1) Evaluation Plan

- The State is required to submit an evaluation design to CMS within 180 days of an approved demonstration or demonstration renewal. The Contractor will be responsible for assisting with the development of the evaluation designs, but the final designs will be determined and finalized between the State and CMS. Past evaluation designs are attached as Attachments D, E and F of this RFP. The evaluation design will be the basis of the future evaluations and will contain the domain and details regarding each evaluation study design, including data collection plans, statistical methods for measuring effects, and level of analysis.

- Each component of the evaluation design will take into consideration the scientific rigor of the analysis, how the analysis will support the determination of cost effectiveness, and how the activities and reporting will be maintained. While demonstration seeks to generate cost savings and promote quality care, observed changes may be attributed to not only a demonstration itself, but also external factors, including other State or national-level policy initiatives and overall market changes and trends. For each demonstration activity, a conceptual framework will be developed depicting how specific demonstration goals, tasks, activities, and outcomes are causally connected to serve as the basis for the evaluation methodology. These methods will be chosen by the DOH to account for any known or possible external influences and their potential interactions with the demonstration's goals and activities.

- The Contractor will gather credible contextual information in an attempt to isolate the demonstration's contribution to any observed effects, as well as describe the relative contributions of other factors that may influence the observed effects. This will include documenting any relevant legal, regulatory, or policy changes or other trends – including the sequence, scope, and duration of such changes – at both a State and national level that are likely to influence the observed outcomes.

- The evaluation will incorporate baseline measures, and account for secular trends, for each of the selected variables included in the evaluation. Data for each of the targeted variables and measures will be collected by the Contractor so that changes in outcome measures and variables can be observed on a longitudinal basis. The evaluation will compare rates of performance and measures with State and national benchmarks, where relevant and feasible. Incorporating benchmark measures will allow for external comparisons of demonstration measures to State and national trends, further isolating the impacts of the demonstration by controlling for external factors influencing the observed effects.

- The evaluation components described above (analysis of qualitative contextual information, the use of baseline measures, data collection, and benchmarking) represent quasi-experimental means by which the Contractor will determine the effects of the demonstration.

- Evaluation conclusions will include key findings associated with individual research questions addressed, as well as integrated information combining the results of individual evaluation questions to make broad conclusions about the effects of the Demonstration. In addition, the evaluation will include specific recommendations of best practices and lessons learned that can be useful for the DOH, other States, and CMS.

2) Revised Plan

- Once an evaluation Plan is returned by CMS, a Revised plan will be due from the Contractor within two (2) months. The expanded evaluation plan will be one (1) comprehensive document that includes the evaluation requirements from the evaluation design, an evaluation timeline and any additional details determined after an orientation is provided by the DOH and in accordance with the STC. The Expanded Evaluation Plan will be submitted by the DOH to CMS, any questions will be answered, and edits made by the Contractor, and then the Expanded Evaluation Plan will be posted on the DOH website upon CMS approval.

- Once the revised plan is approved by CMS, the Contractor will use the plan as a baseline for the evaluations. Previous methods are outlined in the evaluation designs in Attachments D, E and F of this RFP.

- To meet the evaluation goals in the design, the Contractor will use quantitative and qualitative methods.

    - Qualitative methods to be used may be key informant interviews, focus groups, and surveys, with issues to be investigated.

    - Quantitative Data Analysis may include the analysis of Medicaid claims data and data from other large data systems, including the goals of such analyses, manner of data access and data extraction and statistical analysis related to Medicaid demonstrations or waivers, including the types of analyses and software used.

3) Final Summative Evaluation Report

At the end of the demonstration period, a final summative evaluation report is due to the Department within the timeframe required by CMS, historically it has been 18 months after the Demonstration period has ended. The report must cover the entire Demonstration period and contain the major results and conclusions of the waiver program. Content of the reports is described in the STCs.

4) Future Waiver Close Out

At the end of the approved demonstration period, the Department and CMS will decide on the future of the waiver.

- Should the waiver not continue, the Contractor will be responsible for all close-out transition activities as outlined by the Department at time of transition.

- Should the waiver continue, the Contractor will be responsible for:

  - Assisting with the renewal application

  - Preparing an interim evaluation report either at the time of the application submission or one (1) year prior to the end of the demonstration.

  - Following all Close-Out Report activities as outlined in Page 66-67 of the STCs.

C. Miscellaneous Independent Evaluations by Task Order

The Contractor will be responsible for other evaluations services required by:

- CMS,
- DOH for health care quality, equity, cost or budgeting, and/or
- NYS for the public health and safety of New Yorkers.

For the miscellaneous evaluations the Department will initiate a task order request utilizing the process detailed below:

1) The Department will Submit the task order request via email to the Contractor.
   - The task order request will include the specific deliverables required and will include the timeframe in which it will be completed.

2) The Contractor will draft a Statement of Work plan (SOW) to complete the deliverables requested in the task order. SOW must be received within the timeframe stated by the Department in the task order request.

3) Upon receipt of the SOW, the Department will review the SOW and negotiate any changes deemed necessary prior to the Department's final approval. The task order must be approved by the Department prior to the start of work.

The below Tasks will be performed for any CMS required waiver independent evaluations. The independent evaluator will be responsible for completing the evaluation per the terms of the STCs which include, but may not be limited to:

- Evaluation Plan;
- Revised Plan
- Final Report; and,
- Future/closeout waiver activities.

For independent evaluations initiated by DOH staff prior to this contract being executed, the independent evaluator will be required to support the outstanding Tasks/Deliverables for that independent evaluation.

4.2 Staffing

A. Required Individuals

A successful evaluation project will rely on an effective organizational structure and highly productive, motivated, and qualified staff. Overall project staffing must adequately meet the project activities and deliverables. Staff are

expected to have appropriate training and experience in program evaluation, quantitative data collection and analysis using large and complex data systems, statistical programming and analysis, survey and interview development, qualitative data analysis, data programming and software (to facilitate data access), and report preparation.

1) **Project Manager**
The Contractor is required to have a full-time (30 hours per week or greater) project manager who will assure effective communication and coordination of the Independent Evaluation project, including integrity of all products and integrating information from all aspects of the evaluation throughout the course of the contract period. Possessing knowledge of 1115 and/or other independent evaluations is preferred.

2) **Lead Evaluator**
The Contractor is required to have a full-time (30 hours per week or greater) lead evaluator who will lead the development of evaluation requirements, data collection methods, and corresponding tools and documentation to be used during the exercises. The lead evaluator must have at least five (5) years' experience of qualitative and/or quantitative evaluation experience, strong analytical skill using Excel, online reporting tools, or statistical packages such as SAS, SPSS, or STATA.

3) **Other Staffing**
The Contractor is also required to have adequate staffing to ensure that all written products are professionally prepared, clear, accurate, meaningful, and targeted to their intended audience. The Department reserves the right to request additional staffing as deemed necessary.

B. Staffing Approvals

Within 30 calendar days of notice of contract approval by the Office of the State Comptroller (OSC), the Contractor will submit resumes of the staff proposed in the staffing plan for review and approval of the DOH. In the event that a staff member is deemed unacceptable or becomes unavailable during the contract period, the Contractor will submit resumes within 10 business days of notification of the staff unavailability to the DOH for review and approval prior to engaging work from the replacement on this contract.

4.3 Meeting

A. Presentations for CMS

1) In accordance with the STCs, the Contractor will be expected to present to and participate in a discussion with CMS on the expanded evaluation plan and the evaluation reports. These meetings are expected to be conference calls lasting no more than two (2) hours in length. At DOH's request, the Contractor is expected to attend these presentations in person*.

   *In the event the Contractor's staff needs to attend in person, travel costs will be reimbursed separately to the Contractor by the State based upon actual expenses incurred, not to exceed the rate approved by the Office of the State Comptroller. Rules and regulations related to the reimbursement of travel expenses can be found at: https://www.osc.state.ny.us/agencies/travel/part8.htm and current Per Diem Rates can be found at https://www.gsa.gov/node/86696?utm_source=OGP&utm_medium=print-radio&utm_term=portal/category/21287&utm_campaign=shortcuts.

B. Weekly Project Meetings

1) The Contractor will participate in weekly conference call meetings with the DOH (Office of Health Insurance Programs and Office of Quality and Patient Safety) to communicate updates

regarding the Independent Evaluation project, including progress made, challenges encountered, technical questions, presentation of individual analysis findings for technical feedback, and troubleshooting (e.g., data access). Frequency of meetings may be greater than weekly during the initial project start.

4.4 Reporting

The Contractor is responsible for the following reports, which are expected to be prepared accurately and professionally with executive level summaries that clearly convey the findings so that executive staff, including those not possessing formal statistical training, can understand.

A. Evaluation Reports

Per agreement between the New York State Department of Health and CMS, the following reports are due for all listed evaluations in Section 4.1.A. Due dates will be provided upon assignment of evaluations and will be expected to be met. Upon CMS approval of the Evaluation Report, the final report will be posted on the New York State Department of Health website.

4.5 Deliverables

For each of the independent evaluations, the following deliverables will be required:

Independent Evaluation Deliverables (for all outlined IEs, ad hoc, and task orders)

Part A- Evaluation Plan

- Contractor will submit to the Department for approval/edits within 150 days of an approved demonstration

Part B-DOH Revised Plan

- Contractor will provide requested edits to DOH prior to their submission to CMS within 14 calendar days, or as requested by the DOH.

Part C-Final Report

- CMS, DOH or an approving agency as required by DOH approves (after any edits) and is put on the DOH website, if applicable. This is outlined in section 4.1.B.3.

Additional Deliverable Activities

Future Waiver Close Out Activities

- As requested by the Department as outlined in Section 4.1.B.4

4.6 Information Technology

The application and all systems and components supporting it, including but not limited to any forms and databases that include Personal Health, Personal Identification or other New York State information, must comply with all NYS security policies and standards listed at http://its.ny.gov/tables/technologypolicyindex.htm.

A. Data Access and Security

Data sources to be used in the evaluation will be made available to the selected Contractor upon request. These include but are not limited to: Medicaid Data Warehouse, Minimum Data Set (MDS 3.0), MLTC Satisfaction Data, Money Follows the Person (MFP) data, New York State of Health

(NYSoH) Enrollment, Uniform Assessment System-NY (UAS-NY) Community Health Data, and the Statewide Planning and Research Cooperative Systems (SPARCS).

For those data sources identified above that are not housed on intranet network drives (i.e., Medicaid Data Warehouse and NYSoH Enrollment data), the Contractor will be granted user rights to access the systems for this evaluation. Because the periodicity of data refresh varies across sources/systems, the most recently available data cycles may be inconsistent, and adjustments will be made to ensure evaluation periods are consistent and thoroughly explained.

The Department will provide the Contractor with a Virtual Private Network (VPN) connection, privileges, and login ID(s) that provide secure access to the appropriate NYS Medicaid systems and data, to perform the scope of work under this agreement. The Contractor will need information technology staffing (e.g., a programmer) to facilitate data access. The Contractor shall provide a signed copy of a Data Use Agreement (DUA), specifying the data scope, including but not limited to, data elements and date range of the data needed. The Contractor shall be provisioned accounts for authorized users to access the required data in the NYS provided environment in accordance with the terms and conditions of the contract and for the duration of the DUA. Upon award, the Contractor will provide the Department, and maintain on an ongoing basis, the list of those users, including name, position, responsibility, and time period, who will require access to the data. The Contractor must review, update, and submit a list of current authorized users to the Department quarterly. Additionally, the winning bidder must notify the Department immediately, in accordance with the DUA, when an authorized user joins or separates from the project. The Department will authorize users and provision accounts within 30 calendar days of request.

Given public health law and/or data use agreements that govern access to these data, bidders for the Independent Evaluation should be aware that obtaining access will require substantial time and effort, which should be considered when developing the evaluation timeline.

4.7 Security

The selected Contractor shall comply with all privacy and security policies and procedures of the Department (ITS Information Security Policy NYS-P03-002) and applicable State and Federal law and administrative guidance with respect to the performance of the Contract. The Contractor is required, if applicable, to execute a number of security and privacy agreements with the Department including a Business Associate Agreement (Appendix H) and a Data Use Agreement (DUA) at contract signing.

The Contractor is expected to provide secure and confidential backup, storage and transmission for hard copy and electronically stored information. Under no circumstances will any records be released to any person, agency, or organization without specific written permission of the DOH. The Contractor is obligated to ensure any Subcontractor hired by Contractor who stores, processes, analyzes or transmits MCD on behalf of Contractor has the appropriate security requirements in place. Contractor is required to include in all subcontracts and Business Associate Agreements with their Subcontractors language surrounding the security and privacy requirements as well as the language contained in the Confidentiality Language for Third Parties section of the DUA. If any breach or suspected breach of the data or confidentiality occurs, whether the breach occurred with the Contractor or Subcontractor, DOH must be notified immediately.

The Contractor is required to maintain and provide to the Department upon request their data confidentiality plans and procedures for meeting security requirements as they relate to the deliverables and services within this RFP, including all plans as they relate to subcontractor work where applicable.
Contractor will develop and maintain adequate fully trained staff to respond to all stakeholder inquiries while protecting confidentiality and maintaining the security and integrity of all systems. Staff must be trained to understand and observe requirements related to confidentiality and operating guidelines for functions included in this RFP.

The Contractor will comply fully with all current and future updates of the security procedures of the DOH as well as with all applicable State and Federal requirements, in performance of the Contract.

4.8 Transition

The transition represents a period when the current contract activities performed by the Contractor must be turned over to the Department, another Department agent or successor Contractor during or at the end of the Contract Term.

The Contractor shall ensure that any transition to the Department, Departmental agency or successor Contractor be done in a way that provides the Department with uninterrupted *[fill in the services]* services. This includes a complete and total transfer of all data, files, reports, and records generated from the inception of the Contract through the end of the Contract to the Department or another Department agent should that be required during or upon expiration of its contract.

The Contractor shall provide technical and business process support as necessary and required by the Department to transition and assume contract requirements to the Department or another Department agent should that be required during or at the end of the Contract.

The Contractor shall manage and maintain the appropriate number of staff to meet all requirements listed in the RFP during the transition. All reporting and record requirements, security standards, and performance standards are still in effect during the transition period.

Contractor is required to develop a work plan and timeline to securely and smoothly transfer any data and records generated from the inception of the Contract through the end of the Contract to the Department or another Department agent should that be required during or upon expiration of its Contract. The plan and documentation must be submitted to the Department no later than twelve (12) months before the last day of its Contract with the Department of Health or upon request of the Department.

4.9 Payment

Payment of invoices and/or vouchers submitted by the successful Bidder pursuant to the terms of the Contract entered into pursuant to this RFP by the Department shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be:

All deliverables are to be invoiced for within 30 days upon DOH final approval of each deliverable.

4.10 Subcontracting

Bidder's may propose the use of a subcontractor. The Contractor shall obtain prior written approval from DOH before entering into an agreement for services to be provided by a subcontractor. The Contractor is solely responsible for assuring that all the requirements of this RFP are met. All subcontracts shall contain provisions specifying that the work performed by the subcontractor must be in accordance with the terms of the prime contract, and that the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in the agreement between the DOH and the Contractor. DOH reserves the right to request removal of any Bidder's staff or subcontractor's staff if, in DOH's discretion, such staff is not performing in accordance with the Contract.

NOTE: Subcontractors whose contracts are valued at or above $100,000 will be required to submit the Vendor Responsibility Questionnaire upon selection of the prime Contractor.

4.11 Contract Insurance Requirements

Prior to the start of work under the Contract, the Contractor shall procure, at its sole cost and expense, and shall maintain in force at all times during the term of the Contract, insurance of the types and in the amounts set forth in Attachment 8, the New York State Department of Health Contract, Section IV. Contract Insurance Requirements as well as below.

4.12 Minority & Women-Owned Business Enterprise (M/WBE) Requirements

Pursuant to New York State Executive Law Article 15-A, the Department recognizes its obligation to promote opportunities for maximum feasible participation of **certified** minority-and woman-owned business enterprises and the employment of minority group members and women in the performance of DOH contracts.

Business Participation Opportunities for M/WBEs

For purposes of this RFP, DOH hereby establishes an overall goal of 30% for M/WBE participation, 15% for Minority-Owned Business Enterprises ("MBEs") participation and 15% for Women-Owned Business Enterprises ("WBEs"), based on the current availability of qualified MBEs and WBEs and outreach efforts to certified M/WBE firms. The successful Bidder who becomes the Contractor under the Contract entered into with the Department pursuant to this RFP must document good faith efforts to provide meaningful participation by M/WBEs as subcontractors or suppliers in the performance of the Contract consistent with the M/WBE participation goals established for this procurement, and Contractor must agree that DOH may withhold payment pending receipt of the required M/WBE documentation. For guidance on how DOH will determine "good faith efforts," refer to 5 NYCRR §142.8.

The directory of New York State Certified M/WBEs can be viewed at: https://ny.newnycontracts.com. The directory is found in the upper right-hand side of the webpage under "Search for Certified Firms" and accessed by clicking on the link entitled "MWBE Directory". Engaging with firms found in the directory with like product(s) and/or service(s) is strongly encouraged, and all communication efforts and responses should be well documented to establish Contractor's "good faith efforts".

By submitting a Bid in response to this RFP, a Bidder agrees to complete an M/WBE Utilization Plan (Attachment 5, Form #1) for this RFP. DOH will review the submitted M/WBE Utilization Plan. If the Plan is not accepted, DOH may issue a notice of deficiency. If a notice of deficiency is issued, Bidder agrees that it shall respond to the notice of deficiency within seven (7) business days after Bidder's receipt of such notice. DOH may disqualify a Bidder as being non-responsive to this RFP under the following circumstances:

a) If a Bidder fails to submit a M/WBE Utilization Plan;
b) If a Bidder fails to submit a written remedy to a notice of deficiency;
c) If a Bidder fails to submit a request for waiver (if applicable); or
d) If DOH determines that the Bidder has failed to document good-faith efforts to provide meaningful participation by M/WBEs under the Contract in accordance with the goals for this RFP established by the Department;

The Contractor will be required to attempt to utilize, in good faith, any MBE or WBE identified in its M/WBE Utilization Plan, during the performance of the Contract. Requests for a partial or total waiver of established goal requirements made subsequent to Contract Award may be made at any time during the term of the Contract to DOH but must be made no later than prior to the submission of a request for final payment on the Contract.

The Contractor will be required to submit a Contractor's Quarterly M/WBE Contractor Compliance & Payment Report to the DOH, by the 10th day following each end of quarter over the term of the Contract documenting the progress made toward achievement of the M/WBE goals of the Contract.

If (a) the Department determines that the Contractor is not in compliance with the M/WBE requirements of the Contract and the Contractor refuses to comply with such requirements, or (b) the Department finds that the Contractor has willfully and intentionally failed to comply with the M/WBE participation goals established in the Contract, the Contractor may be required to pay to the Department liquidated damages.

Such liquidated damages shall be calculated as an amount equaling the difference between: (1) all sums identified for payment to M/WBEs had the Contractor achieved the contractual M/WBE goals; and (2) all sums actually paid to M/WBEs for work performed or materials supplied under the Contract.

A New York State certified Minority- and Women-Owned Businesses (M/WBE) may request that their firm's contact information be included on a list of M/WBE firms interested in serving as a subcontractor for this procurement. The listing will be publicly posted on the Department's website for reference by the bidding community. A firm requesting inclusion on this list should send contact information and a copy of its NYS M/WBE certification to OHIPcontracts@health.ny.gov before the Deadline for Questions as specified in Section 1. (Calendar of Events). Nothing prohibits an M/WBE Vendor from proposing as a prime Contractor.

Please Note: Failure to comply with the foregoing requirements may result in a finding of non-responsiveness, non-responsibility and/or a breach of the Contract, leading to the withholding of funds, suspension or termination of the Contract or such other actions or enforcement proceedings as allowed by the Contract.)

4.13 Participation Opportunities for NYS Certified Service-Disabled Veteran-Owned Businesses

Article 17-B of the New York State Executive Law provides for more meaningful participation in public procurement by NYS-certified Service-Disabled Veteran-Owned Businesses ("SDVOBs"), thereby further integrating such businesses into New York State's economy. DOH recognizes the need to promote the employment of service-disabled veterans and to ensure that certified service-disabled veteran-owned businesses have opportunities for maximum feasible participation in the performance of DOH contracts.

In recognition of the service and sacrifices made by service-disabled veterans and in recognition of their economic activity in doing business in New York State, Bidders/Contractors are strongly encouraged and expected to consider SDVOBs in the fulfillment of the requirements of the Contract. Such participation may be as subcontractors or suppliers, as protégés, or in other partnering or supporting roles.

For purposes of this procurement, DOH conducted a comprehensive search and determined that the Contract does not offer sufficient opportunities to set specific goals for participation by SDVOBs as subcontractors, service providers, and suppliers to Contractor. Nevertheless, Bidder/Contractor is encouraged to make good faith efforts to promote and assist in the participation of SDVOBs on the Contract for the provision of services and materials. The directory of New York State Certified SDVOBs can be viewed at: https://ogs.ny.gov/veterans/

Bidders are encouraged to contact the Office of General Services' Division of Service-Disabled Veteran's Business Development at 518-474-2015 or VeteransDevelopment@ogs.ny.gov to discuss methods of maximizing participation by SDVOBs on the Contract.

5.0 ADMINISTRATIVE INFORMATION

The following administrative information will apply to this RFP. Failure to comply fully with this information may result in disqualification of your proposal.

5.1 Restricted Period

"Restricted period" means the period of time commencing with the earliest written notice, advertisement, or solicitation of a Request for Proposals ("RFP"), Invitation for Bids ("RFP"), or solicitation of proposals, or any other method for soliciting a response from bidders intending to result in a procurement contract with DOH and ending with the final contract award and approval by DOH and, where applicable, final contract approval by the Office of the State Comptroller.

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

This prohibition applies to any oral, written, or electronic communication under circumstances where a reasonable person would infer that the communication was intended to influence this procurement. Violation of any of the requirements described in this Section may be grounds for a determination that the bidder is non-

responsible and therefore ineligible for this contract award. Two (2) violations within four (4) years of the rules against impermissible contacts during the "restricted period" may result in the violator being debarred from participating in DOH procurements for a period of four (4) years.

5.2 Questions

Potential Bidders may submit written questions and requests for clarification pertaining to this RFP between the issuance of this RFP and the deadline for the submission of written questions specified in Section 1 of this RFP (Calendar of Events). All questions and requests for clarification of this RFP should cite the relevant RFP, including the RFP number and title (RFP 20374 and Independent Evaluation of New York State Health Insurance and Waiver Programs), the section and paragraph number of this RFP or of the Attachment to this RFP to which the question relates, where applicable, and must be submitted via email to [*insert a BML or other contact information here*] no later than the Deadline for Submission of Written Questions specified in Section 1 of this RFP. (Calendar of Events). Questions received after the deadline **may not** be answered.

If a potential Bidder discovers any ambiguity, conflict, discrepancy, omission, or other apparent error in this RFP, the Bidder shall immediately notify DOH of such error in writing at OHIPcontracts@health.ny.gov and request that DOH clarify or modify the Terms of this RFP. If, prior to the deadline for the Submission of Bids, a Bidder fails to notify DOH of a known error or an error that reasonably should have been known, the Bidder shall assume the risk of bidding notwithstanding such apparent ambiguity, conflict, discrepancy, omission or other error. If awarded the Contract pursuant to the terms of this RFP, the Bidder shall not be entitled to an amendment to the terms of the Contract to correct or clarify any such ambiguity, conflict, discrepancy, omission or other error nor to any additional compensation by reason of the error or its correction.

5.3 Right to Modify RFP

DOH reserves the right to modify any part of this RFP, including but not limited to, the date and time by which proposals must be submitted and received by DOH, at any time prior to the Deadline for Submission of Proposals specified in Section 1.0 (Calendar of Events). Modifications to this RFP shall be made by issuance of amendments and/or addenda.

Prior to the Deadline for Submission of Proposals, any such clarifications or modifications as deemed necessary by DOH will be posted to the DOH website.

If a prospective bidder discovers any ambiguity, conflict, discrepancy, omission, or other error in this RFP, the bidder shall immediately notify DOH of such error in writing at ohipcontracts@health.ny.gov and request clarification or modification of the RFP.

If, prior to the Deadline for Submission of Proposals, a bidder fails to notify DOH of a known error or an error that reasonably should have been known, the bidder shall assume the risk of proposing. If awarded the Contract, the bidder shall not be entitled to additional compensation by reason of the error or its correction.

5.4 DOH's Reserved Rights

The Department of Health reserves the right to:

1. Reject any or all proposals received in response to the RFP;
2. Withdraw the RFP at any time, at the Department's sole discretion;
3. Make an award under the RFP in whole or in part;
4. Disqualify any bidder whose conduct and/or proposal fails to conform to the requirements of the RFP;
5. Seek clarifications and revisions of proposals;
6. Use proposal information obtained through site visits, management interviews and the State's investigation of a bidder's qualifications, experience, ability or financial standing, and any material or information submitted by the bidder in response to the Department's request for clarifying information in the course of evaluation and/or selection under the RFP;
7. Prior to the bid opening, amend the RFP specifications to correct errors or oversights, or to supply additional information, as it becomes available;

8. Prior to the bid opening, direct bidders to submit proposal modifications addressing subsequent RFP amendments;
9. Change any of the scheduled dates;
10. Eliminate any mandatory, non-material specifications that cannot be complied with by all of the prospective bidders;
11. Waive any requirements that are not material;
12. Negotiate with the successful bidder within the scope of the RFP in the best interests of the State;
13. Conduct contract negotiations with the next responsible bidder, should the Department be unsuccessful in negotiating with the selected bidder;
14. Utilize any and all ideas submitted in the proposals received;
15. Every offer shall be firm and not revocable for a period of three hundred and sixty-five days from the bid opening, to the extent not inconsistent with section 2-205 of the uniform commercial code. Subsequent to such three hundred and sixty- five days, any bid is subject to withdrawal communicated in a writing signed by the bidder; and,
16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of a bidder's proposal and/or to determine a bidder's compliance with the requirements of the solicitation.

5.5 Debriefing

Once an award has been made, a Bidder may request a debriefing of their Bid. The debriefing will be limited solely to the Bidder's own Bid and will not include any discussion of other bids. A Bidder's request for a debriefing must be received by the Department no later than fifteen (15) calendar days after the date of the award notification to the successful Bidder or non-award announcement to the unsuccessful Bidder, depending upon whether the Bidder requesting the debriefing is the successful Bidder or an unsuccessful Bidder.

5.6 Protest Procedures

In the event an unsuccessful Bidder wishes to protest the award resulting from this RFP, the protesting Bidder must follow the protest procedures established by the Office of the State Comptroller (OSC). These procedures can be found in Chapter XI Section 17 of the OSC's Guide to Financial Operations, which is available on-line at: http://www.osc.state.ny.us/agencies/guide/MyWebHelp/

5.7 Freedom of Information Law ("FOIL")

All Bids may be disclosed or used by the Department to the extent permitted by law. The Department may disclose a Bid to any person for the purpose of assisting in evaluating the Bid or for any other lawful purpose. All Bids will become State agency records, which will be available to the public in accordance with the New York State Freedom of Information Law. **Any portion of the Bid that a Bidder believes constitutes proprietary information entitled to confidential handling, as an exception to the Freedom of Information Law, must be clearly and specifically designated in the Bid as specified in Section 6.1.2. of this RFP.** If the Department agrees with the proprietary claim, the designated portion of the Bidder's Bid will be withheld from public disclosure. Blanket assertions of proprietary material will not be accepted, and failure to specifically designate proprietary material may be deemed a waiver of any right to confidential handling of such material.

5.8 Piggybacking

New York State Finance Law section 163(10)(e) (see also https://ogs.ny.gov/procurement/piggybacking-using-other-existing-contracts-0) allows the Commissioner of the NYS Office of General Services to consent to the use of the Contract entered into pursuant to this RFP by other New York State Agencies, and other authorized purchasers, subject to conditions and the Contractor's consent.

6.0 PROPOSAL CONTENT

The following includes the format and information to be provided by each Bidder. Bidders responding to this RFP must satisfy all requirements stated in this RFP. All Bidders are requested to submit complete

Administrative and Technical Proposals, and are required to submit a complete Cost Proposal. A proposal that is incomplete in any material respect may be rejected.

To expedite review of the proposals, Bidders are requested to submit proposals in separate Administrative, Technical, and Cost packages inclusive of all materials as summarized in Attachment A, Proposal Documents. This separation of information will facilitate the review of the material requested. No information beyond that specifically requested is required, and Bidders are requested to keep their submissions to the shortest length consistent with making a complete presentation of qualifications. Evaluations of the Administrative, Technical, and Cost Proposals received in response to this RFP will be conducted separately. Bidders are therefore cautioned not to include any Cost Proposal information in the Technical Proposal documents.

DOH will not be responsible for expenses incurred in preparing and submitting the Administrative, Technical, or Cost Proposals.

6.1 Administrative Proposal

The Administrative Proposal should contain all items listed below. An Administrative Proposal that is incomplete in any material respect may be eliminated from consideration. The information requested should be provided in the prescribed format. Responses that do not follow the prescribed format may be eliminated from consideration. All responses to the RFP may be subject to verification for accuracy. Please provide the forms in the same order in which they are requested.

6.1.1 Bidder's Disclosure of Prior Non-Responsibility Determinations

Submit a completed and signed Attachment 1, "Prior Non-Responsibility Determinations."

6.1.2 Freedom of Information Law – Proposal Redactions

Bidders must clearly and specifically identify any portion of their proposal that a Bidder believes constitutes proprietary information entitled to confidential handling as an exception to the Freedom of Information Law. See Section 5.7, (Freedom of Information Law)

6.1.3 Vendor Responsibility Questionnaire

Complete, certify, and file a New York State Vendor Responsibility Questionnaire. DOH recommends that bidders file the required Vendor Responsibility Questionnaire online via the New York State VendRep System. To enroll in and use the New York State VendRep System, see the VendRep System Instructions at http://www.osc.state.ny.us/vendrep/index.htm or go directly to the VendRep System online at www.osc.state.ny.us/vendrep.

Bidders must provide their New York State Vendor Identification Number when enrolling. To request assignment of a Vendor ID or for VendRep System assistance, contact the OSC Help Desk at 866-370-4672 or 518-408-4672 or by email at ciohelpdesk@osc.state.ny.us.

Bidders opting to complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website, www.osc.state.ny.us/vendrep, or may contact the Office of the State Comptroller's Help Desk for a copy of the paper form. Bidders should complete and submit the Vendor Responsibility Attestation, Attachment 3.

6.1.4 Vendor Assurance of No Conflict of Interest or Detrimental Effect

Submit Attachment 4, Vendor Assurance of No Conflict of Interest or Detrimental Effect, which includes information regarding the Bidder, members, shareholders, parents, affiliates and subcontractors. Attachment 4 must be signed by an individual authorized to bind the Bidder contractually.

6.1.5 M/WBE Forms

Submit completed Form #1 and/or Form #2, Form #4 and Form #5 as directed in Attachment 5, "Guide to New York State DOH M/WBE RFP Required Forms."

6.1.6 Encouraging Use of New York Businesses in Contract Performance

Submit Attachment 6, "Encouraging Use of New York State Businesses in Contract Performance" to indicate the New York Businesses you will use in the performance of the Contract.

6.1.7 Bidder's Certified Statements

Complete, sign and submit Attachment 7, "Bidder's Certified Statements", which includes information regarding the Bidder. Attachment 7 must be signed by an individual authorized to bind the Bidder contractually. Please indicate the title or position that the signer holds with the Bidder.

6.1.8 References

Provide references using Attachment 9 (References) for three projects that demonstrate the ability of the Bidder to perform jobs similar in scope to the size, nature, and complexity of this RFP and demonstrate that the Bidder possesses the minimum qualifications stated in Section 3.1 of this RFP . Provide firm names, addresses, contract names, telephone numbers, and email addresses.

6.1.9 Diversity Practices Questionnaire

The Department has determined, pursuant to New York State Executive Law Article 15-A, that the assessment of the diversity practices of respondents to this procurement is practical, feasible, and appropriate. Accordingly, respondents to this procurement should include as part of their response to this procurement, Attachment 10 "Diversity Practices Questionnaire". Responses will be formally evaluated and scored.

6.1.10 Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination

Bidder should complete and submit Attachment 11 certifying that it does not have institutional policies or practices that fail to address the harassment and discrimination of individuals on the basis of their age, race, creed, color, national origin, sex, sexual orientation, gender identity, disability, marital status, military status, or other protected status under the Human Rights Law.

6.1.11 Executive Order 16 Prohibiting Contracting with Businesses Conducting Business in Russia

Bidder should complete and submit Attachment 12 certifying the status of their business operations in Russia, if any, pursuant to Executive Order 16.

6.1.12 State Finance Law Consultant Disclosure Provisions

In accordance with New York State Finance Law Section 163(4)(g), State agencies must require all Contractors, including subcontractors, that provide consulting services for State purposes pursuant to a contract to submit an annual employment report for each such contract.

The successful bidder for procurements involving consultant services must complete a "State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term" in order to be eligible for a contract.

The successful bidder must also agree to complete a "State Consultant Services Form B, Contractor's Annual Employment Report" for each state fiscal year included in the resulting contract. This report must be submitted annually to the Department, the Office of the State Comptroller, and Department of Civil Service.

Submit State Consultant Services Form A: Contractor's Planned Employment and Form B: Contractor's Annual Employment Report , available at: http://www.osc.state.ny.us/agencies/forms/ac3271s.doc and http://www.osc.state.ny.us/agencies/forms/ac3272s.doc.

6.1.13 Sales and Compensating Use Tax Certification (Tax Law, § 5-a)

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain Contractors awarded state contracts for commodities, services and technology valued at more than $100,000 to certify to the Department of Tax and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to contracts where the total amount of such contractor's sales delivered into New York State are in excess of $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any affiliates and subcontractors whose sales delivered into New York State exceeded $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

This law imposes upon certain contractors the obligation to certify whether or not the contractor, its affiliates, and its subcontractors are required to register to collect state sales and compensating use tax and contractors must certify to DTF that each affiliate and subcontractor exceeding such sales threshold is registered with DTF to collect New York State and local sales and compensating use taxes. The law prohibits the State Comptroller, or other approving agencies, from approving a contract awarded to an offeror meeting the registration requirements but who is not so registered in accordance with the law.

The successful Bidder must file a properly completed Form ST-220-CA with the Department ^ and Form ST-220-TD with the DTF. These requirements must be met before a contract may take effect. Further information can be found at the New York State Department of Taxation and Finance's website, available through this link: http://www.tax.ny.gov/pdf/publications/sales/pub223.pdf.

Submit these Forms, available through these links:

- ST-220 CA: http://www.tax.ny.gov/pdf/current_forms/st/st220ca_fill_in.pdf
- ST-220 TD: http://www.tax.ny.gov/pdf/current_forms/st/st220td_fill_in.pdf

6.2 Technical Proposal

The purpose of the Technical Proposal is to demonstrate the qualifications, competence, and capacity of the Bidder to perform the services contained in this RFP. The Technical Proposal should demonstrate the qualifications of the Bidder and the staff to be assigned to provide services related to the services included in this RFP.

A Technical Proposal that is incomplete in any material respect may be eliminated from consideration. The following outlines the information requested to be provided by Bidders. The information requested should be provided in the prescribed format. Responses that do not follow the prescribed format may be eliminated from consideration. All responses to the RFP may be subject to verification for accuracy.

While additional data may be presented, the following should be included. Please provide the information in the same order in which it is requested. Your proposal should contain sufficient information to assure DOH of its accuracy. Failure to follow these instructions may result in disqualification.

Pricing information contained in the Cost Proposal cannot be included in the Technical Proposal documents.

6.2.1 Title Page

Submit a Title Page providing the RFP subject and number; the Bidder's name and address, the name, address, telephone number, and email address of the Bidder's contact person; and the date of the Proposal.

6.2.2 Table of Contents

The Table of Contents should clearly identify all material (by section and page number) included in the Bidder's proposal.

6.2.3 Documentation of Bidder's Eligibility Responsive to Section 3.0 of RFP

Bidders must be able to meet all the requirements stated in Section 3.0 of the RFP. The bidder must submit documentation that provides sufficient evidence of meeting the criterion/criteria set forth in Section 3.0. This documentation may be in any format needed to demonstrate how the Bidder meets the minimum qualifications to propose.

DOH will accept proposals from organizations with the following types and levels of experience and qualifications as a prime contractor.

- A minimum of three (3) years of experience conducting large-scale (at least one [1] million lives), multi-year program evaluations, including completion of at least one (1) such evaluation;
- A minimum of three (3) years of experience performing statistical analyses using claims and encounter data;
- A minimum of three (3) years of experience performing each of the following:
    - Statewide or CMS designated Medicaid region comparisons;
    - Longitudinal evaluations; and
    - Collecting and analyzing qualitative and quantitative data.
- At the time of bid, the bidder and any proposed subcontractor(s) must attest to not having any direct business relationship with any Medicaid MCO:
    - Medicaid Managed Care (MMC);
    - Health and recovery Plans (HARP);
    - Human Immunodeficiency Virus Special Needs Plans (HIV SNP);
    - Medicaid Long Term Care Plan (MLTCP);
    - Medicaid Advantage Plan (MAP);
    - Program of All-inclusive Care for the Elderly (PACE); and,
    - Self-Directed Care (SDC) pilot site agencies.

Experience acquired concurrently is considered acceptable.

For the purposes of this RFP, a prime contractor is defined as one who has the contract with the owner of a project or job and has full responsibility for its completion. A prime contractor undertakes to perform a complete contract and may employ (and manage) one or more subcontractors to carry out specific parts of the contract. However, a prime contractor may not leverage the experience of a planned subcontractor in order to meet the Minimum Qualifications identified above.

Failure to meet these Minimum Qualifications will result in a proposal being found non-responsive and eliminated from consideration.

6.2.4 Technical Proposal Narrative

The Technical Proposal should provide satisfactory evidence of the Bidder's ability to meet, and expressly respond to, each element listed below.

Elements of the Technical Proposal are as follows:

A. Organizational Background and Experience

a. Describe the experience your organization has with conducting large-scale multi-year program evaluations.

b. Describe the experience your organization has with performing statewide or CMS

designated Medicaid region comparisons, longitudinal evaluations, and collecting and analyzing qualitative and quantitative data.

c. Identify three projects similar to the scope of this RFP and provide a summary of scope and outcome of the project.

B. Project Implementation

a. Describe how your organization will assist with the development and submission of Evaluation Plans as identified in Section 4.1.C of this RFP.

b. Describe your organization's proposed process, including any special tools and techniques, for completing revisions to the Revised Evaluation Plan as identified in Section 4.1.C of the RFP.

c. Describe how the use of qualitative and quantitative analysis methods will inform the goals of the evaluation design under the resulting engagement.

d. Describe how your organization will go about drafting and submitting a final summative evaluation report at the end of the demonstration period.

e. Describe how your organization will perform the future waiver close out activities when requested by the Department.

f. Describe how your organization will plan for and present on CMS discussions on the expanded evaluation plan and the evaluation reports.

C. Staffing Requirements

a. Describe how your organization's proposed staff will meet the requirements as outlined in Section 4.2. This should include a high-level staffing organization chart to indicate proposed staffing under the project.

D. Reporting

a. Describe the plan to submit a monthly progress report outlining information as listed in Section 4.4 of this RFP.

E. Information Technology and Security

a. Describe your organization's process for complying with all NYS security policies and standards, as well as the data access and security policies as outlined Section in 4.6 & 4.7 of this RFP.

F. Transition

a. Describe your organization's approach for adhering to the transition requirements as described in Section 4.8 of this RFP.

6.3 Cost Proposal

Submit a completed and signed Attachment B **– Cost Proposal.** The Cost Proposal shall comply with the format and content requirements as detailed in this RFP and in Attachment B. Failure to comply with the format and content requirements may result in disqualification.

The bid price is to cover the cost of furnishing all of the product(s)/ services sought to be procured, including but not limited to travel, materials, equipment, overhead, profit and labor to the satisfaction of the Department ^ and the performance of all work set forth in said specifications.

7.0 PROPOSAL SUBMISSION

A proposal consists of three distinct parts: (1) the Administrative Proposal, (2) the Technical Proposal, and (3) the Cost Proposal. Proposals should be submitted in all formats as prescribed below.

Submit a complete Proposal via email to: ohipcontracts@health.ny.gov with the subject "Offer RFP #20374 Independent Evaluation of New York State Health Insurance and Waiver Programs." Include, as attachments to the email, three complete distinct PDF files labeled "Administrative Offer", "Technical Offer" and "Cost Proposal" In the event an electronic submission cannot be read by the Department, the Department reserves the right to request a hard copy and/or electronic resubmission of any unreadable files. The Bidder shall have 2 business days to respond to such requests and must certify the resubmission is identical to the original submission. Hardcopy will prevail.

The proposal must be received by the DOH, no later than the Deadline for Submission of Proposals specified in Section 1.0, (Calendar of Events). Late bids will not be considered.

7.1 No Bid Form

Bidders choosing not to bid are requested to complete the No-Bid form, Attachment 2. Although not mandatory, such information helps the Department direct solicitations to the correct bidding community.

8.0 METHOD OF AWARD

8.1 General Information

DOH will evaluate each proposal based on the "Best Value" concept. This means that the proposal that best "optimizes quality, cost, and efficiency among responsive and responsible offerers" shall be selected for award (State Finance Law, Article 11, §163(1)(j)).

DOH, at its sole discretion, will determine which proposal(s) best satisfies its requirements. DOH reserves all rights with respect to the award. All proposals deemed to be responsive to the requirements of this procurement will be evaluated and scored for technical qualities and cost. Proposals failing to meet the requirements of this RFP may be eliminated from consideration. The evaluation process will include separate technical and cost evaluations, and the result of each evaluation shall remain confidential until evaluations have been completed and a selection of the winning proposal is made.

The evaluation process will be conducted in a comprehensive and impartial manner, as set forth herein, by an Evaluation Committee. The Technical Proposal and compliance with other RFP requirements (other than the Cost Proposal) will be weighted **80%** of a proposal's total score and the information contained in the Cost Proposal will be weighted **20%** of a proposal's total score.

Bidders may be requested by DOH to clarify the contents of their proposals. Other than to provide such information as may be requested by DOH, no Bidder will be allowed to alter its proposal or add information after the Deadline for Submission of Proposals listed in Section 1.0 (Calendar of Events).

In the event of a tie, the determining factors for award, in descending order, will be:

(1) lowest cost and
(2) proposed percentage of M/WBE participation.

8.2 Submission Review

DOH will examine all proposals that are received in a proper and timely manner to determine if they meet the proposal submission requirements, as described in Section 6.0 (Proposal Content) and Section 7.0 (Proposal Submission), including documentation requested for the Administrative Proposal, as stated in this RFP.

Proposals that are materially deficient in meeting the submission requirements or have omitted material documents, in the sole opinion of DOH, may be rejected.

8.3 Technical Evaluation

The evaluation process will be conducted in a comprehensive and impartial manner. A Technical Evaluation Committee comprised of Program Staff of DOH will review and evaluate all proposals.

Proposals will undergo a preliminary evaluation to verify Minimum Qualifications to Propose (Section 3.0).

The Technical Evaluation Committee members will independently score each Technical Proposal that meets the submission requirements of this RFP. The individual Committee Member scores will be averaged to calculate the Technical Score for each responsive Bidder.

The Technical Proposal evaluation is **80% (up to 80 points)** of the final score.

8.4 Cost Evaluation

The Cost Evaluation Committee will examine the Cost Proposal documents. The Cost Proposals will be opened and reviewed for responsiveness to cost requirements. The Cost Evaluation Committee will sum the proposed price for each of the following deliverables: Evaluation Plan, Revised Plan, Final Report, and Waiver Close Out Activities for each program resulting in a total cost. The Cost Evaluation Committee will then sum all of the totals to obtain a total bid amount. If a cost proposal is found to be non-responsive, that proposal may not receive a cost score and may be eliminated from consideration.

The Cost Proposals will be scored based on a maximum cost score of 20 points. The maximum cost score will be allocated to the Cost Proposal with the lowest all-inclusive not-to-exceed maximum price. All other responsive proposals will receive a proportionate score based on the relation of their Cost Proposal to the Cost Proposal(s) offered at the lowest final cost, using this formula:

C = (A/B)* 20%
A is Total price of lowest Cost Proposal;
B is Total price of Cost Proposal being scored; and
C is the Cost score.

The Cost Proposal evaluation is **20% (up to 20 points)** of the final score.

8.5 Composite Score

A composite score will be calculated by the DOH by adding the Technical Proposal points and the Cost Proposal points awarded. Finalists will be determined based on composite scores.

8.6 Reference Checks

The Proposer should submit references using Attachment 9 (References). At the discretion of the Evaluation Committee, references may be checked at any point during the process to verify the Proposer's qualifications to propose (Section 3.0).

8.7 Best and Final Offers

DOH reserves the right to request best and final offers. In the event DOH exercises this right, all Bidders that submitted a proposal that are susceptible to award will be asked to provide a best and final offer. Bidders will be informed that should they choose not to submit a best and final offer, the offer submitted with their proposal will be construed as their best and final offer.

8.8 Award Recommendation

The Evaluation Committee will submit a recommendation for award to the Bidder(s) with the highest composite score(s) whose experience and qualifications have been verified.

The Department will notify the awarded Bidder(s) and Bidders not awarded. The awarded Bidder(s) will enter into a Contract substantially in accordance with the terms of Attachment 8, DOH Agreement, to provide the required product(s) or services as specified in this RFP. The resultant Contract shall not be binding until fully executed and approved by the New York State Office of the Attorney General and the Office of the State Comptroller.

9.0 ATTACHMENTS

The following attachments are included in this RFP and are available via hyperlink or can be found at: https://www.health.ny.gov/funding/forms/.

1. Bidder's Disclosure of Prior Non-Responsibility Determinations
2. No-Bid Form
3. Vendor Responsibility Attestation
4. Vendor Assurance of No Conflict of Interest or Detrimental Effect
5. Guide to New York State DOH M/WBE Required Forms & Forms
6. Encouraging Use of New York Businesses in Contract Performance
7. Bidder's Certified Statements
8. DOH Agreement (Standard Contract)
9. References
10. Diversity Practices Questionnaire
11. Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination
12. Executive Order 16 Prohibiting Contracting with Business Conducting Business in Russia

The following attachments are attached and included in this RFP:

A. Proposal Document Checklist
B. Cost Proposal
C. Medicaid MCO Direct Business Relationship Attestation
D. 2019 1115 Evaluation Design
E. 1115 Demonstration Evaluation Logic Models
F. Managed Long Term Care (MLTC)
G. Individuals Moved from Institutional Settings to Community Settings for Long Term Services and Supports
H. Mainstream Medicaid Managed Care Data Table
I. Frequently Used Acronyms

ATTACHMENT A
PROPOSAL DOCUMENT CHECKLIST
Please reference Section 7.0 for the appropriate format and quantities for each proposal submission.

RFP20374 – Independent Evaluation of New York State Health Insurance and Waiver Programs		
FOR THE ADMINISTRATIVE PROPOSAL		
RFP §	**SUBMISSION**	**INCLUDED**
§ 6.1.1	Attachment 1 - Bidder's Disclosure of Prior Non-Responsibility Determinations	☐
§ 6.1.2	Freedom of Information Law – Proposal Redactions (If Applicable)	☐
§ 6.1.3	Attachment 3 - Vendor Responsibility Attestation	☐
§ 6.1.4	Attachment 4 - Vendor Assurance of No Conflict of Interest or Detrimental Effect	☐
§ 6.1.5	M/WBE Participation Requirements:	☐
	Attachment 5 - Form 1	☐
	Attachment 5 - Form 2 (If Applicable)	☐
	Attachment 5 - Form 4	☐
	Attachment 5 - Form 5 (If Applicable)	☐
§ 6.1.6	Attachment 6 - Encouraging Use of New York Businesses	☐
§ 6.1.7	Attachment 7 - Bidder's Certified Statements	☐
§ 6.1.8	Attachment 9 - References	☐
§ 6.1.9	Attachment 10 - Diversity Practices Questionnaire	☐
§ 6.1.10	Attachment 11 - EO 177 Prohibiting Contracts with Entities that Support Discrimination	☐
§ 6.1.11	Attachment 12 – EO 16 Contracting with Businesses Conducting Business in Russia	☐
§ 6.1.12	State Finance Law Consultant Disclosure	☐
§ 6.1.13	Sales and Compensating Use Tax Certification	☐
§ 3.1	Attachment C - Medicaid MCO Direct Business Relationship Attestation	☐
FOR THE TECHNICAL PROPOSAL		
RFP §	**SUBMISSION**	**INCLUDED**
§ 6.2.1	Title Page	☐
§ 6.2.2	Table of Contents	☐
§ 6.2.3	Documentation of Bidder's Eligibility (Requirement)	☐
§ 6.2.4	Technical Proposal Narrative	☐
FOR THE COST PROPOSAL REQUIREMENT		
RFP §	**REQUIREMENT**	**INCLUDED**
§ 6.3	Attachment B- Cost Proposal	☐

ATTACHMENT B COST PROPOSAL RFP #20374
Vendor Name _____

To complete the Cost Proposal, Bidders must provide a price per waiver for each deliverable below.

i.e., In the first row, the bidder will propose four (4) prices for the 1115 Waiver, Medicaid Managed Plan Program Independent Evaluation. The bidder will propose a price for each of the following deliverables: Evaluation Plan, Revised Plan, Final Report, and Waiver Close Out Activities (as requested).

The contractor will not be reimbursed for any costs incurred outside of the prices provided in the below Attachment B: Cost Proposal. The contractor will invoice as outlined in Section 5.4 Payment

WAIVER	PROGRAM	Hours (5yr) (estimated)	Evaluation Plan (a)	Revised Plan (b)	Final Report (c)	Future Waiver close out activities (as request)
1115	Medicaid Managed Care	15,000				
1115	Health and Recovery Plan (HARP)	10,000				
1115	Self-Directed Care (SDC)	10,000				
1115	Managed Long-Term Care (MLTC)	10,000				
1115	HIV Special Needs Plans (SNPS)	10,000				
1915c	Nursing Home Transition and Diversion (NHTD)	10,000				
1915c	Children's Waiver	10,000				
CMS 438.6c	Individual State Directed Payment models	10,000				
TBD	Other evaluation plan designs or evaluation	5,000				

WAIVER	PROGRAM	Hours (5yr) (estimated)	Evaluation Plan (a)	Revised Plan (b)	Final Report (c)	Future Waiver close out activities (as request)
	services required by CMS					
N/A	Other evaluation plan designs or evaluation services required by DOH for health care quality purposes	5,000				
N/A	Other evaluation plan designs or evaluation services required by DOH for health care equity purposes	5,000				
N/A	Other evaluation plan designs or evaluation services required by DOH for health care cost purposes	5,000				
N/A	Other evaluation plan designs or evaluation services required by DOH for health care budgeting purposes	5,000				

By signing this Cost Proposal Bid Sheet, bidder agrees that the prices above are binding for 365 days from the proposal due date.

Date: _____ Signature: _____

Print Name and Title: _____

ATTACHMENT C
Medicaid MCO Direct Business Relationship Attestation

At the time of bid, the bidder and any proposed subcontractor(s) must attest to not having any direct business relationship with any Medicaid Managed Care Organization (MCO):

- Medicaid Managed Care (MMC);
- Health and recovery Plans (HARP);
- Human Immunodeficiency Virus Special Needs Plans (HIV SNP);
- Medicaid Long Term Care Plan (MLTCP);
- Medicaid Advantage Plan (MAP);
- Program of All-inclusive Care for the Elderly (PACE); and,
- Self-Directed Care (SDC) pilot site agencies.

By signing this document, the bidder attests to the above statement and to remain out of any direct business relationships with the above MCOs throughout the time of the potential contract.

Date: _____ Signature: _____

Print Name and Title: _____

ATTACHMENT D
2019 1115 Evaluation Design

The evaluation will include pre-post analyses and comparisons to national benchmarks focusing on the followingdomains of the 1115 Demonstration:

1. Individuals Receiving Long Term Supports and Services (LTSS)
   - Managed Long -Term Care (MLTC)
   - Individuals moved from institutional settings to community settings for LTSS

2. Mainstream Medicaid Managed Care (MMMC) and Temporary Assistance to Needy Families (TANF).

Each component of the comprehensive evaluation design within this RFP was written by the New York State Department of Health with consideration for the scientific rigor of the analysis, how the analysis will support the determination of cost effectiveness, and how the activities and reporting will be maintained. While the Demonstration seeks to generate cost savings and promote quality care, observed changes may be attributed to not only the Demonstration itself, but also external factors, including other State- or national-level policy initiatives and overall market changes and trends. For each Demonstration activity, a conceptual framework was developed depicting how specific Demonstration goals, tasks, activities, and outcomes are causally connected to serve as the basis forthe evaluation methodology. These methods were chosen by the New York State Department of Health to accountfor any known or possible external influences described above and their potential interactions with the Demonstration's goals and activities.

<u>Evaluation Design</u>
The Contractor will gather credible contextual information in an attempt to isolate the Demonstration's contributionto any observed effects, as well as describe the relative contributions of other factors that may influence the observed effects. This will include documenting any relevant legal, regulatory, or policy changes or other trends – including the sequence, scope, and duration of such changes – at both a State and national level that are likely to influence the observed outcomes.

The evaluation will incorporate baseline measures, and account for secular trends, for each of the selected variables included in the evaluation. Data for each of the targeted variables and measures will be collected by the Contractor so that changes in outcome measures and variables can be observed on a longitudinal basis. The evaluation will compare rates of performance and measures with State and national benchmarks, where relevant and feasible. Incorporating benchmark measures will allow for external comparisons of Demonstration measures to State and national trends, further isolating the impacts of the Demonstration by controlling for external factors influencing theobserved effects.
The evaluation components described above (analysis of qualitative contextual information, the use of baseline measures, data collection, and benchmarking) represent quasi-experimental means by which the Contractor will determine the effects of the Demonstration.

Evaluation conclusions will include key findings associated with individual research questions addressed, as well as integrated information combining the results of individual evaluation questions to make broad conclusions about the effects of the Demonstration. In addition, the evaluation will include specific recommendations of best practices and lessons learned that can be useful for the DOH, other States, and CMS.

The evaluation design for each domain, and details regarding each evaluation study design, including datacollection plans, statistical methods for measuring effects, and level of analysis, are outlined below.

Attachment E contains general logic models for the interventions specific to each of the domains and programs within the 1115 Demonstration. Attachments F, G and H describe the goals, research questions, and hypothesesfor each of the domains contained within the evaluation. Applicable measures and data sources for each of the research questions are also described within these attachments. The following is a description of the evaluation design including relevant sources of data.

Domain 1. Individuals Receiving Long Term Supports and Services

Study Population

New York's Medicaid Redesign Team Section 1115 Demonstration contains two (2) components related to Long Term Supports and Services (LTSS) delivery. First, it requires individuals in need of more than 120 days of community-based long-term care to enroll in a MLTC plan to receive LTSS as well as other ancillary services. Second, the demonstration allows MLTC-eligible individuals who are discharged from a nursing home or adult homeinto the community to qualify for enrollment into a MLTC plan using a special income standard. For this evaluation,the second group, the Home and Community Based Services (HCBS) expansion group, will be considered a subsetof the larger population.

1. Managed Long-Term Care (MLTC)

The MLTC plans are required to collect and report to the New York State Department of Health information on enrollees' levels of functional and cognitive impairment, behaviors, and clinical diagnoses. This information is collected at enrollment and then semi-annually thereafter. From 2005 through September 2013, these data werecollected using the Semi-Annual Assessment of Members (SAAM) instrument, a modified version of the federal (Medicare) Outcome and Assessment Information Set (OASIS-B). The SAAM was used to establish clinical eligibility for the MLTC program and assist health providers in care planning and outcome monitoring.

Beginning on October 1, 2013, the SAAM instrument was replaced by the Uniform Assessment System New York(UAS-NY) Community Health Assessment instrument which may include a Functional Supplement and/or Mental Health Supplement. The UAS-NY is an electronic system based on a uniform data set, which standardizes and automates needs assessments for home and community based programs in New York. Whether using the SAAMinstrument or the UAS-NY, functional status data remain critical to inform eligibility for the MLTC program, provide the basis for the MLTC plans' care management planning processes, and facilitate a plan's identification of areas where the patient's status differs from optimal health or functional status.

Submission of assessment data occurred twice a year with the SAAM instrument. Now, assessment data are submitted by plans to the UAS-NY electronically as assessments are conducted, and are added to the database upon submission. Each year, the Department concatenates the MLTC UAS-NY submissions to create two (2) static assessment files. One file contains the most recent assessment for enrollees in each plan from January through June. The second contains the most recent assessment for enrollees in each plan from July through December. These two (2) files are used by the Department to describe and evaluate the MLTC plan performance.

Given the change of assessment instrument and mandatory nature of the MLTC program, the Contractor will evaluate post-intervention trends by examining New York State Department of Health calculated performance metrics overtime. Because New York has two (2) static files from which quality measures are derived, January through June and July through December, rates from both datasets will be utilized by the Contractor in their trendanalysis.

The broad goals of the New York MLTC program evaluation are to assess the impact of the Demonstration onoutcomes measured through: 1) Expanded access for MLTC for Medicaid enrollees in need of long-term careservices and supports; 2) Stability or Improvement in Patient Safety; 3) Stability or Improvement in Quality of Care; 4) Stability or Reduction in preventable acute

hospital admissions; and 5) Stability or Improvement in consumer satisfaction. Toward these goals, the following evaluation questions will be addressed:

Goal 1: To expand access to MLTC for Medicaid enrollees in need of long-term services and supports.

Question: Enrollment into MLTC will continue to grow and then stabilize as the program is mandatory across theState. At what point in the demonstration did the population stabilize in size?

Hypothesis: The MLTC program experienced rapid growth but stabilized over the course of the demonstration.

Methods: Using New York State Department of Health enrollment numbers, the Contractor will quantitativelyassess the growth of the program over the Demonstration.

Data Sources:
- DOH Enrollment data

Goal 2: Demonstrate stability or improvement in patient safety

Question 1: Is the percent of the MLTC population having an emergency room visit in the last 90 days sinceassessment stable or improving over the course of the demonstration?

Question 2: Is the percent of the MLTC population having a fall, as defined by the Department's fall measure,stable or improving over the course of the demonstration?

Hypothesis: The MLTC performance on patient safety measures has remained stable or improved over thecourse of the demonstration.

Methods: Using New York State Department of Health computed six-month rates, the Contractor will qualitativelyassess if the percent of the MLTC population having an emergency room visit or a fall is stable or improving overthe course of the Demonstration.

Data Sources:
- UAS-NY Community Health data

Goal 3: Demonstrate stability or improvement in quality of care

Question 1: Are enrollees' perceived timely access to personal, home care and other services such as dentalcare, optometry and audiology stable over time or improving?

Questions 2: Is the percent of the MLTC population accessing preventive care services such as the flu shot anddental care consistent or improving?

Hypothesis: The MLTC performance on quality of care and satisfaction measures has remained stable orimproved over the course of the demonstration
Methods: The New York State Department of Health sponsors a satisfaction survey of the MLTC membership every other year. Using Department calculated satisfaction rates, the Contractor will qualitatively assess if the percent of the MLTC population is stable or improving in their perceived timeliness to access to services such asdental care, optometry and audiology over the course of the Demonstration. The Contractor will also qualitativelyassess, using Department computed six-month rates of access, if enrollees are stable or improved on accessingpreventative services such as flu shots and dental care.

Data Sources:
- UAS-NY Community Health data

- MLTC Satisfaction data

Goal 4: To stabilize or reduce preventable acute hospital admissions

Question: Is the MLTC population experiencing stable or reduced rates of potentially avoidable hospitalization?

Hypothesis: Rates of potential avoidable hospitalizations will remain stable or be reduced over the Demonstration.

Methods: Using rates calculated annually by the DOH, the Contractor will qualitatively assess if the rate of potentially avoidable hospitalizations are remaining stable or improving over the Demonstration. These results willshow the effectiveness of the Waiver in reducing avoidable hospitalizations.

Data Sources:
- UAS-NY Community Health data
- SPARCS data

Goal 5: Demonstrate stability or improvement in consumer satisfaction

Question 1: What is the percent of members who rated their MLTC plan within the last six months as good orexcellent? And, has this percentage remained stable or improved over the Demonstration?

Question 2: What is the percent of members who rated the quality of care manager/case manager services withinthe last six months as good or excellent? And, has this percentage remained stable or improved over the Demonstration?

Question 3: What is the percent of members who, in the last six months, rated their home health aide/personalcare aide/personal assistant, care manager/case manager, regular visiting nurse or covering/on call nurse services as usually or always on time? And, has this percentage remained stable or improved over the Demonstration?

Question 4: What is the percent of members who, in the last six months, rated the quality of home health aide/personal care aide/personal assistant services as good or excellent? And, has this percentage remainedstable or improved over the Demonstration?

Hypothesis: Rates of satisfaction will remain stable or improve over the Demonstration.

Methods: New York State Department of Health sponsors a satisfaction survey of the MLTC membership every other year. Using DOH calculated satisfaction rates, the Contractor will qualitatively assess if the rating of satisfaction with the member's plan, care manager, and home health aide, has remained stable or improved overthe Demonstration.

Data Sources:
- MLTC Satisfaction data

The research questions, measures, and data sources for each of these goals for the MLTC program aredescribed in Attachment F.

2. Individuals Moved from Institutional Settings to Community Settings for Long-Term Services and Supports

The broad goals of New York's HCBS expansion program are to assess the impact of the Demonstration on: 1)Improve Access to MTLC for those that transitioned from an institutional setting to the community; 2) Stability orImprovement in Patient Safety; 3) Stability or Improvement in Quality of Care. Toward these goals, the followingevaluation questions will be addressed:

Goal 1: Improve Access to MTLC for those who transitioned from an institutional setting to the community

Question 1: For those who transition from an institutional setting to the community, did the percent enrolling inMLTC increase over the Demonstration?

Hypothesis: The percent of institutional discharges to the community enrolling in MLTC will increase over thecourse of the Demonstration.

Methods: Using DOH calculated rates, the Contractor will quantitatively assess the growth of the transitionpopulation over the Demonstration.

Data Sources:

- UAS-NY Community Health data
- MFP data
- MDS 3.0

Goal 2: Stability or Improvement in Patient Safety

Question 1: Is the percent of the HCBS expansion population having an emergency room visit in the last 90 dayssince assessment stable or improving over the course of the Demonstration?

Question 2: Is the percent of the HCBS expansion population having a fall, as defined by the Department's fallmeasure, stable or improving over the course of the Demonstration?

Hypothesis: The performance on these patient safety measures for the HCBS expansion population will remainstable or improved over the course of the Demonstration

Methods: Using DOH computed six-month rates, the Contractor will qualitatively assess if the percent of the HCBS expansion population having an emergency room visit or a fall is stable or improving over the course of theDemonstration.

Data Sources:

- UAS-NY Community Health data
- MFP data

Goal 3: Stability or Improvement in Quality of Care

Question 1: For the HCBS expansion population that entered MLTC after transitioning from an institutional setting,what percent return to the nursing home within a year of discharge, what was their average level of care need andfor those that return within a year, how long on average did they reside in the community?

Question 2: Is the percent of the HCBS expansion population accessing preventive care services such as the flushot and dental care consistent or improving?
Hypothesis: For the HCBS expansion population, performance on these quality of care measures will remainstable or improved over the course of the demonstration

Methods: Using DOH calculated rates stratified by level of care on the UAS assessment, the Contractor will qualitatively assess if the annual HCBS expansion population rate of remaining in the community remained stableor improved over the course of demonstration. The Contractor will also qualitatively assess, using Department computed six-month rates, access to preventive care services is stable or improved for the HCBS population.

Data Sources:

- UAS-NY Community Health data
- MFP data
- MDS 3.0

The research questions, measures, and data sources for each of these goals for the community transitions program are described in Attachment F.

Domain 2. Mainstream Medicaid Managed Care and TANF

Goal 1: To increase access to health insurance through Medicaid enrollment

Express Lane-like Eligibility refers to a Medicaid process through which individuals applying for Temporary Assistance (TA) are automatically considered for Medicaid enrollment without having to file a separate application. The underlying rationale is that Medicaid eligibility determination and enrollment can be facilitated given that, in most cases, applicants for TA are also eligible for Medicaid given the lower income threshold for the former. While Express Lane Eligibility does not represent a newly implemented Medicaid enrollment procedure, itsauthority under the 1115 Waiver, applied to adults, is a recent change.

Given the program objective of increasing access to health insurance through Medicaid by streamlining theapplication and enrollment process, the following questions will be addressed in the evaluation:

Question 1: How many recipients are enrolled through Express Lane-like Eligibility?

Question 2: Are there differences in the demographic and clinical characteristics of Medicaid beneficiariesenrolled through Express Lane-like Eligibility as compared to those not enrolled through this mechanism?

Question 3: What portion of the beneficiaries enrolled through Express Lane-like Eligibility were later deemed tobe ineligible for coverage?

Hypotheses:

1. The number of recipients enrolled through this mechanism will remain steady through the Waiver period.
2. Differences in demographic and clinical characteristics of Medicaid beneficiaries should be similar inpatterns seen for other types of Medicaid aid category.
3. Because the eligibility levels for receiving TA are lower than for Medicaid only, it is unlikely that manybeneficiaries will be retroactively ineligible.

Methods: While Express Lane-like Eligibility is not a new Medicaid enrollment procedure, there has not been a mechanism available within the Medicaid enrollment system to identify if recipients were enrolled with this procedure. Tracking of the number of recipients enrolled into Medicaid under Express Lane-like initiatives is nowdone through an identifier which is created for all new enrollment records. The number and percentage of recipients enrolled through the Express Lane-like Eligibility mechanism will be determined monthly and annually over the duration of the Demonstration. Medicaid claims and enrollment data will be used to compare recipients enrolled through the Express Lane-like mechanism to those enrollees who did not, on demographic and clinical factors. A list of enrollees enrolled through this mechanism over a selected two-year period during the Demonstration will be used to identify those individuals in the database. It is anticipated that a two-year period will be a sufficient time frame to identify enoughenrollees to allow comparisons to be made. From the claims and enrollment data, demographic (age, sex, race/ethnicity, New York State region) and clinical information (presence or absence of chronic diseases, such asmental illness and diabetes, and maternal/delivery) will be extracted, with comparisons to be made between

Express Lane-like enrollment vs. non-Express Lane-like enrollment using analytic procedures such as chi-square analysis.

Data Sources:

- Medicaid Data Warehouse
- NYSoH Enrollment Files

Goal 2: To limit gaps in Medicaid eligibility due to fluctuations in recipient income – Twelve-Month ContinuousEligibility Period Initiative

The Twelve-Month Continuous Eligibility initiative, initiated in 2014 with the Affordable Care Act Marketplace, is toprevent lapses in Medicaid coverage due to fluctuations in recipient income, and applies to Medicaid recipients eligible under Modified Adjusted Gross Income (MAGI) guidelines. MAGI eligibility groups include the following:

- Pregnant women;
- Infants and children under the age of 19;
- Childless adults who are: not pregnant, age 19-64, not on Medicare, or could be certified as disabledbut not on Medicare;
- Parents/Caretaker relatives;
- Family Planning Benefit Program; and
- Children in foster care.

MAGI recipients remain eligible for Medicaid until renewal after a 12-month period, during which time recipients are not required to report changes in income, and such changes are not considered even if they are reported bythe recipient. Changes in eligibility would be made in cases such as of death, moving out of state, or voluntary disenrollment in Medicaid.

Evaluation of the Twelve-Month Continuous Eligibility for MAGI Individuals program is to provide information toprogram managers on how effectively continuous enrollment is being implemented, the potential health care benefits associated with 12-month continuous eligibility, as well as possible effects on health care costs. Such information could potentially be used to make program modifications toward increasing effectiveness in preventing lapses in coverage to ensure greater inclusion of subgroups that may be underserved with this initiative and to encourage use of preventive services resulting from increased Medicaid coverage to prevent more severe disease preventing potentially higher costs.

The broad goal of the Twelve-Month Continuous Eligibility initiative is to limit gaps in Medicaid coverage due tofluctuations in recipient income. Toward this goal, the following questions will be addressed:

Question 1: What is the distribution of enrollees within select continuous enrollment cohorts (i.e., 12 months, 24months, etc.)?

Question 2: Does continuous enrollment differ by demographic or clinical characteristics?

Question 3: Did Medicaid's average months of continuous enrollment increase following the implementation ofcontinuous eligibility as compared to pre-implementation?

Question 4: Was there an increase in the percentage of Medicaid beneficiaries continuously enrolled for 12months following implementation of continuous eligibility as compared to pre-implementation?

Question 5: How do outpatient, inpatient, and emergency department visits compare pre- and post-implementation of this policy? How have costs been impacted because of the change in utilization?

Question 6: How many of the beneficiaries covered under continuous eligibility would have been ineligible forcoverage if not for the waiver?

Hypotheses:

1. Given the mechanism of 12-month continuous eligibility to prevent lapses in Medicaid coverage, monthsof enrollment per member will show an increase over the five (5) years following the implementation of 12-month continuous eligibility as compared to the five (5) years preceding its implementation. Similarly,the number of enrollees with 12 months continuous enrollment will show an increase over the five (5) years preceding implementation.
2. The use of primary care and other preventive services will increase following the implementation of 12- month continuous eligibility. This is expected due to the anticipated continuity of coverage resulting fromthe initiative.
3. Health care costs for primary care and selected preventive care services will increase following the implementation of 12-month continuous eligibility, given the expected increase in utilization of theseservices.

Methods: MAGI Medicaid enrollees will be identified, based on aid category codes, in the enrollment data fromJanuary 1, 2014 through December 31, 2018. Medicaid enrollment history for these recipients will be used to determine the number and proportion of recipients who had at least one 12-month period of continuous enrollment during this period.

To understand the characteristics of MAGI recipients who receive 12-month enrollment, those with 12-month enrollment over the five-year period will be compared to MAGI recipients not showing 12-month enrollment in theirenrollment histories. Demographic variables on which comparisons will be made include sex, race, and age.
Additionally, the presence or absence of chronic diseases will be compared between these two (2) groups as of the recipients' first month of enrollment in Medicaid occurring on or after January 1, 2014. Comparisons will be made, using chi-square analysis, on the presence or absence of conditions such as HIV/AIDS, diabetes, seriousmental illness, asthma, cardiovascular disease and kidney disease. Clinical Risk Group (CRG) categories and/ordiagnosis codes on claims will be used to determine the presence of these conditions.

Medicaid enrollment data will be used to determine months of enrollment per recipient. This will be determined foreach of the five (5) years prior to implementation of 12-month continuous eligibility (January 1, 2011 – December 31, 2013) and each of the five (5) years following implementation (January 1, 2014 – December 31, 2018).

An interrupted time series design[1] will test hypotheses assessing the effect of the 12-month continuous eligibility initiative on Medicaid enrollment. This is a quasi-experimental design in which summary measures of the outcomevariable (annual months of enrollment per member, in this case) are taken at equal time intervals over a period prior to program implementation, followed by a series of measurements at the same intervals over a period following program implementation. This design was chosen in consideration of the fact that a control group is unlikely to be available, limiting the ability to separate the effects of this initiative from other statewide health care reform initiatives that are ongoing (e.g., DSRIP, the Affordable Care Act). Given the limitation resulting from the likely absence of a comparison group, this design is advantageous in that potential confounders (i.e., other health care reform initiatives) are minimized in that they would have to occur contemporaneously with the introduction of 12-month continuous eligibility to exert a confounding effect, which is unlikely, but is recognized as possible nonetheless. This design also has the advantage of accounting for secular trends in the enrollment months per member, to which other health care reform initiatives may contribute.

[1] Cook TD, Campbell DT (1979). Quasi-experimentation: Design and analysis for field settings. Boston, MA: Houghton Mifflin Company.

Segmented regression[2] will be used as the primary analytic strategy in the analysis of data under the interrupted time series design in testing hypotheses. This analysis enables the evaluation of changes in the level and trend in the outcome variable, while controlling, as necessary, for such biases as secular trend, serial autocorrelation, and seasonal fluctuation in the outcome variable. A potential issue to address over the study period is change in characteristics of the Medicaid population over time. This could occur through increased enrollment of younger and healthier people into Medicaid, and/or increased movement of older and sicker people from Medicaid fee-for-service to managed care, either of which could confound the effects of the 12-month continuous eligibility initiative on member months of Medicaid enrollment. This will be addressed through adjustment of the outcome variable by standardizing on factors such as age, sex, and health status (e.g., Clinical Risk Grouping[3], Charlson Comorbidity Index[4]), or inclusion of population-level measures of these variables as covariates in the model. Additionally, stratification will be used to assess differential program effects on months of Medicaid enrollment by recipient subgroups (e.g., sex, race, age, NYS region, mental health status). Results will be stratified by demographic and clinical recipient subgroups to assess differential program effects.

To test the hypothesis that the percentage of recipients continuously enrolled for 12 months will increase in the years following the implementation of this initiative, the dependent variable will be the proportion of enrollees continuously enrolled over a 12-month period, in each of the five (5) years prior to implementation of 12-month continuous eligibility, and the five (5) years after.

Again, potential confounding due to changes in the Medicaid population will be controlled through standardizing the outcome variable on factors such as age, sex, and health status, or inclusion of such variables in the model, with stratification on various recipient subgroups to assess differential program effects.

The interrupted time series design will also be used to evaluate cost and utilization of primary and preventive care before and after program implementation. To control for the effect of year-to-year fluctuation in Medicaid enrollment on service utilization and cost, per member per year rates will be computed as the dependent variable in each analysis, for each of the five (5) years prior to, and five (5) years after, the start of the 12-month continuous eligibility initiative.

Medicaid claims data will be used to identify primary care and selected preventive services, including well-care, screening for cancer and management of chronic disease. Costs associated with these services, as well as total care costs, will also be determined from Medicaid claims, to be used in computing the outcome variables for the second and third hypotheses, respectively. To compute per member per year rates for each of these services, the total number of services of each type paid by Medicaid each year will be determined and divided by the total number of months of enrollment over all recipients for that year and the resulting quotient multiplied by 12. Cost per member per year associated with primary care and preventive services, and for total health care costs, will be computed in the same manner.

Prior to implementation of the 12-Month Continuous Eligibility Initiative, Medicaid enrollees were subject to loss of coverage if their incomes rose above the eligibility threshold. Given that Medicaid enrollees are not required to provide information on changes in income until time of eligibility renewal after 12 months, individuals who would otherwise have lost coverage will likely be undercounted. Since the implementation of the New York State of Health (NYSoH) enrollment system, these types of changes are automatically captured. However, enrollees who apply through the local district offices will not have these records available. While increased numbers of enrollees

[2] Gillings, D, Makuc, D, Siegel, E. Analysis of interrupted time series mortality trends: An example to evaluateregionalized perinatal care. American Journal of Public Health 1981; 71; 38-46.

[3] Averill RF, Goldfield NI, Eisenhandler J, et al. Development and Evaluation of Clinical Risk Groups (CRGs).Wallingford, Conn: 3M Health Information Systems. Final Report to the National Institutes of Standards and Technology, US Department of Commerce; 1999.

[4] Charlson ME, Pompei P, Ales KL, and Mackenzie CR (1987). A new method of classifying prognostic comorbidity in longitudinal studies: Development and validation. Journal of Chronic Diseases, 40(5): 373-383.
come into the system through NYSoH, a large portion have not yet enrolled through NYSoH. Records of changesin eligibility will not be available for this cohort.

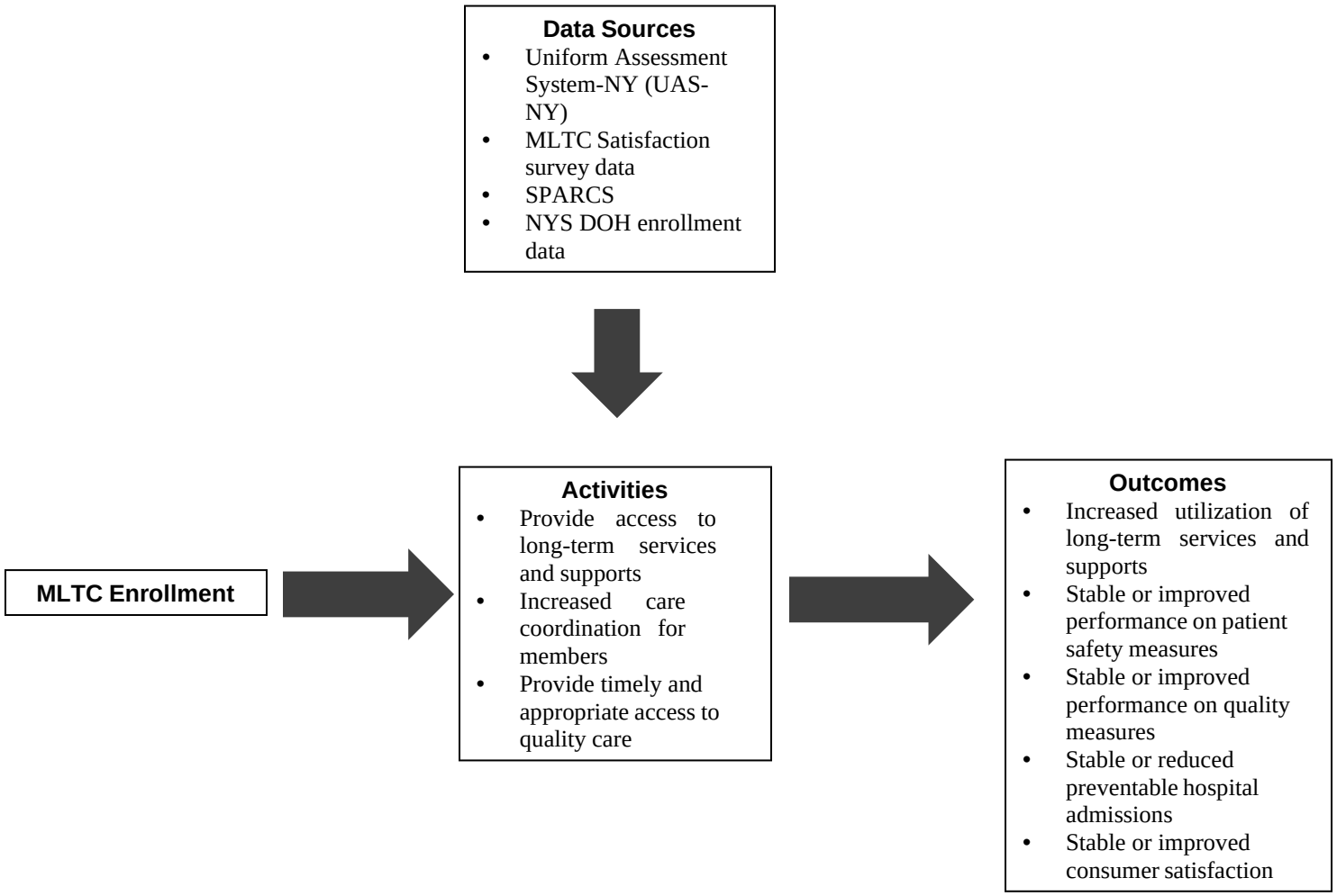
Data Sources:

- Medicaid Data Warehouse
- NYSoH Enrollment Files

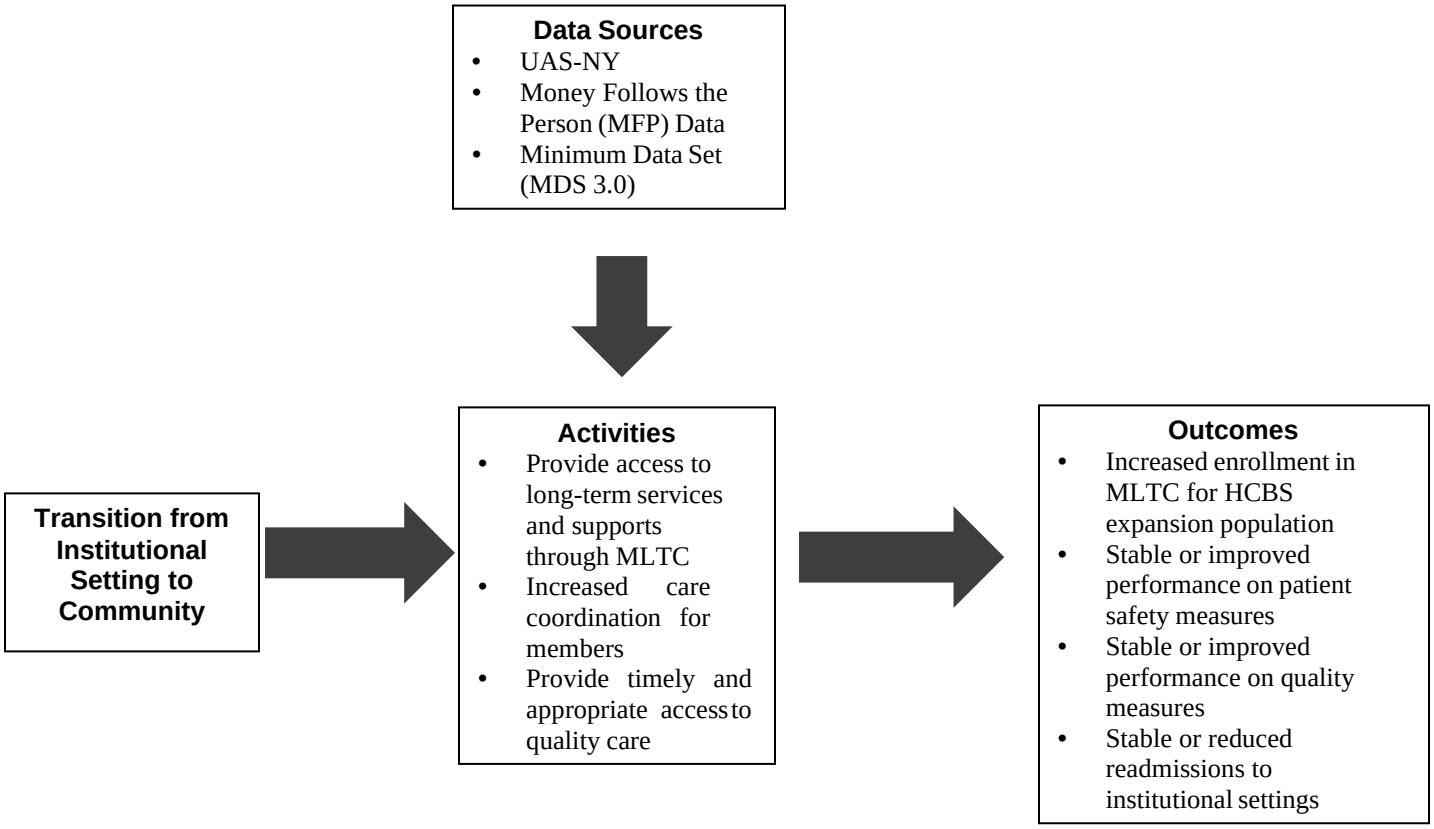
The research questions, measures, and data sources for each of these goals for the MMMC program aredescribed in Attachment H.

ATTACHMENT E
1115 Demonstration Evaluation Logic Models

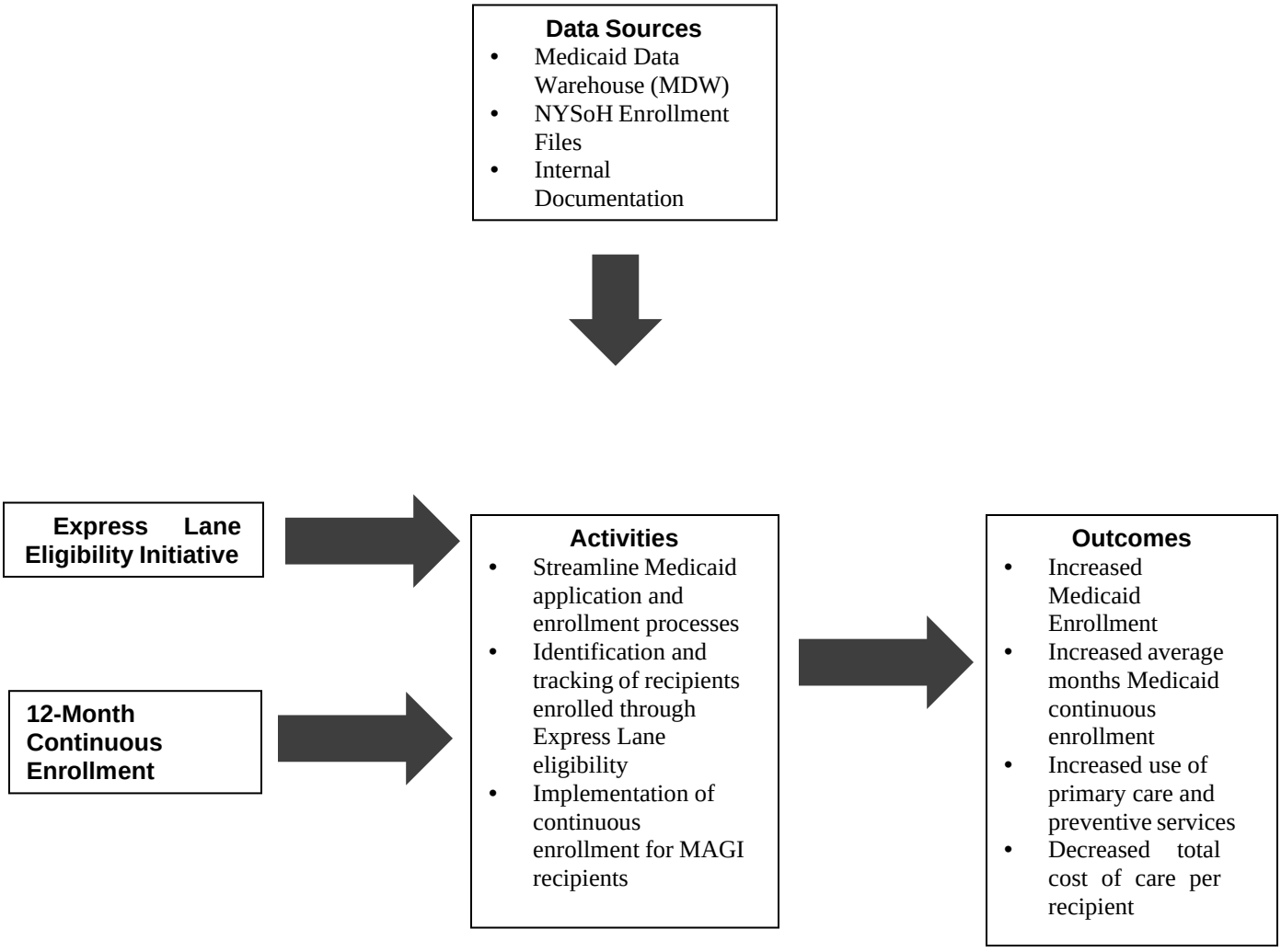
Domain 1 – Individuals Receiving Long-Term Supports and Services
Medicaid Managed Long Term Care (MLTC) Logic Model



Domain 1 – Individuals Receiving Long-Term Supports and Services
Individuals Moved from Institutional Settings to Community Settings Logic Model



Domain 2 – Mainstream Medicaid Managed Care (MMMC) & TANF Logic Model



ATTACHMENT F
Managed Long-Term Care (MLTC)

Goal 1: To expand access to Managed Long-Term Care for Medicaid enrollees in need of long-term services and supports

	Research Questions	Hypothesis	Measures/Variables	Measure Steward	Data Sources
1	Enrollment into MLTC will continue to grow and then stabilize as the program is mandatory across the State. At what point in the demonstration did the population stabilize in size?	The MLTC program experience rapid growth but stabilized over the course of the demonstration.	DOH Enrollment data	N/A	Uniform Assessment System New York (UAS-NY)

Goal 2: To demonstrate stability or improvement in patient safety

	Research Questions	Hypothesis	Measures/Variables	Measure Steward	Data Sources
1	Is the percent of the MLTC population having an emergency room visit in the last 90 days since assessment stable or improving over the course of the demonstration?	The MLTC performance on patient safety measures will remained stable or improved over the course of the demonstration.	Risk-adjusted percentage of members who did not have an emergency room visit in the last 90 days.	DOH	UAS-NY
2	Is the percent of the MLTC population having a fall requiring medical intervention in the last 90 days since assessment stable or improving over the course of the demonstration?	The MLTC performance on patient safety measures will remained stable or improved over the course of the demonstration.	Risk-adjusted percentage of members who did not have falls that required medical intervention in the last 90 days.	DOH	UAS-NY

Goal 3: To demonstrate stability or improvement in quality of care

	Research Questions	Hypothesis	Measures/Variables	Measure Steward	Data Sources
1	Are enrollees perceived timely access to personal,home care and other services such as dental care, optometry and audiology stable over timeor improving?	The MLTC performance on quality of care measures has remained stable orimproved over thecourse of the demonstration	The timeliness of care provided by home health aide, personal care aide,personal assistant. Getting timely urgent appointments with dental care, optometry, andaudiology	DOH DOH	Biennial Satisfactio nSurvey
2	Is the percent of the MLTCpopulation accessing preventive care services such as the flu shot and dental care consistent or improving?	The MLTC performance on quality of care measures has remained stable or improved over the course of the demonstration	Percent of members who received an influenza vaccinationin the last year. Percent of memberswho received a dental exam in the last year.	DOH DOH	UAS-NY

Goal 4: To stabilize or reduce preventable acute hospital admissions

	Research Questions	Hypothesis	Measures/Variables	Measure Steward	Data Sources
1	Is the MLTC populationexperiencing stable or reduced rates of potentially avoidable hospitalization?	Rates of potential avoidable hospitalizations will remain stable or be reduced over the demonstration.	Risk-adjusted potentially avoidablehospitalization measure.	DOH	UAS-NY SPARCS

Goal 5: Demonstrate stability or improvement in consumer satisfaction

	Research Questions	Hypothesis	Measures/Variables	Measure Steward	Data Sources
1	Percent of members who rated their managed long- term care plan within the last six months as good orexcellent? Percent of members who rated the quality of care manager/case manager services within the last six months as good or excellent? Percent of members who in the last six months rated their home health aide/personalcare aide/personal assistant, care manager/case manager, regular visiting nurse or covering/on call nurse services were usually or always on time? Percent of members who rated thequality of home health aide/personal care aide/personal assistant services within the last sixmonths as good or excellent?	Rates of satisfaction will remain stable or improve over thedemonstration	Risk-adjusted percentage of members who ratedtheir managed long-term care plans as good or excellent. Risk-adjusted percentage of members who ratedthe quality of care manager/case manager services within the last six months as good or excellent. Risk-adjusted percentage of members who rated that within the last six months the homehealth aide/personalcare aide/personal assistant, care manager/case manager, regular visiting nurse/registered nurse or covering/on-call nurse services wereusually or always ontime Risk-adjusted percentage of members who ratedthe quality of home health aide/personalcare aide/personal assistant services within the last six months as good or excellent.	DOH DOH DOH DOH	Biennial Satisfactio nsurvey

Evaluation

Annually, or for some measures biannually, New York will calculate the proposed evaluation measures/variables. The Department of Health has extensive experience with the computation and evaluation of quality performance measurement with a variety of service

delivery entities, such as hospitals, managed careorganizations, managed long-term care organizations, and nursing homes. The MLTC program has been mandatory in NYS since 2012, as more previously excluded groups are added to the waiver, the appropriate evaluation is a qualitative analysis of stability or improvement in the plan performance using DOH calculated rates.

Data Sources

Uniform Assessment System-NY (UAS-NY) Community Health data

The MLTC plans are required to collect and report to the DOH information on enrollees' levels of functional and cognitive impairment, behaviors, and clinical diagnoses. This information is collected at enrollment and then semi-annually thereafter. The UAS-NY is an electronic system based on a uniform data set, which standardizes and automates needs assessments for home and community based programs in New York. The UAS-NY is based on the interRAI suite of assessment instruments. interRAI is a collaborative network of researchers in over 30 countries committed to improving health care for persons who are elderly, frail, or disabled. Their goal is to promote evidence-based clinical practice and policy decisions through the collection and interpretation of high quality data. The interRAI organization and its assessment tools are used in many states, as well as Canada and other countries. Using the UAS-NY tool facilitates access to programs and services, eliminates duplicative assessment data, and improves consistency in the assessment process. With the UAS-NY, functional status datademonstrates its importance to inform eligibility for the MLTC program, provide the basis for the MLTC plans' care management planning processes, and facilitate a plan's identification of areas where the patient's status differs from optimal health or functional status.

Assessment data are submitted by plans to the UAS-NY electronically as assessments are conducted, and areadded to the database upon submission. Each year, MLTC UAS-NY submissions are created into two static
assessment files. One containing the most recent assessment for enrollees in each plan from January through June. The second containing the most recent assessment for enrollees in each plan from July through December.These two files will be used to describe and evaluate the MLTC plan performance.

Satisfaction data

In 2007, the DOH, in consultation with the MLTC plans, developed a satisfaction survey of MLTC enrollees. The survey was field tested and is now administered by the DOH's external quality review organization, IPRO.New York State sponsors the biennial MTLC satisfaction survey. The survey contained three sections: health plansatisfaction; satisfaction with select providers and services, including timeliness of care and access; and self- reported health status.

SPARCS

Statewide Planning and Research Cooperative System (SPARCS) data is an all-payor hospital database in New York State. UAS-NY records that matched to SPARCS and had a SPARCS primary diagnosis of respiratory infection, urinary tract infection, congestive heart failure, anemia, sepsis, or electrolyte imbalance were included inthe numerator for the PAH measure. Plan days for members with plan enrollment of greater than 90 days, were summed by plan to create the plan denominator and overall to create the statewide denominator.

ATTACHMENT G
Individuals Moved from Institutional Settings to Community Settings for Long Term Services and Supports

Goal 1: To expand access

	Research Questions	Hypothesis	Measures/Variables	Measure Steward	Data Sources
1	For those that transition from an institutional setting to the community, did the percent enrolling in a MLTC increase over the demonstration?	The percent of institutional discharges to the community enrolling in MLTC will increase over the course of the demonstration.	Percent of MFP populations that enrollees in MTLC within one year or less of discharge.	DOH	UAS-NY MFP master data MDS 3.0

Goal 2: Stability or Improvement in Patient Safety

	Research Questions	Hypothesis	Measures/Variables	Measure Steward	Data Sources
1	For the HCBS Expansion population that transitioned from an institutional setting, what percent will experience less emergency room use in the year post-discharge as compared to pre- discharge?	The performance on patient safety measures for the HCBS Expansion population will remained stable or improved over the course of the demonstration	Risk-adjusted percentage of HCBS Expansion population who did not have an emergency room visit in the last 90 days.	DOH	MFP master data UAS-NY
2	Is the percent of the HCBS Expansion population having a fall requiring medical intervention in the last 90 days since assessment stable or improving over the course of the demonstration?	The performance on patient safety measures for the HCBS Expansion population will remained stable or improved over the course of the demonstration	Risk-adjusted percentage of HCBS Expansion population who did not have falls that required medical intervention in the last 90 days.	DOH	MFP master data UAS-NY

Goal 3: Stability or Improvement in Quality of Care

	Research Questions	Hypothesis	Measures/Variables	Measure Steward	Data Sources
1	For the HCBS Expansion population that entered MLTC aftertransitioning from an institutional setting, what percent return to the nursing home withina year of discharge, what was their average level of care need and for those that return within a year, how long on average did they reside in the community?	The HCBS Expansion population performance on quality of care measures will remained stable orimproved over thecourse of the demonstration	Percent of HCBS Expansion population who remained in the community for one year post dischargeby level of care. Average residency time in the community for HCBS Expansion population who returned to the Nursing Home withinone year.	DOH DOH	UAS-NY MFP master data MDS 3.0
2	Is the percent of theHCBS Expansion population accessing preventive care services such as the flu shot and dental care consistent or improving?	The HCBS Expansion population performance on quality of care measures will remained stable orimproved over thecourse of the demonstration	Percent of HCBS Expansion population who received an influenza vaccinationin the last year. Percent of HCBSExpansion population who received a dentalexam in the last year.	DOH DOH	UAS-NY MFP master data MDS 3.0

Evaluation

This evaluation will use the Money Follows the Person (MFP) program to identify the HCBS cohort. It will utilize theelderly adult and the physically disabled subgroups, excluding the developmentally disabled and the traumatic brain injury groups. The Quality of Life survey will not be assessed; it does not contain questions that address satisfactionwith access or timeliness and quality of providers and services nor is the sample adequate.

Data Sources

MFP Master File
The Money Follows the Person (MFP) program group within the Department will annually provide to the Office of Quality and Patient Safety their master case file. This master file will be matched by the Department to the UAS toidentify MFP program members who enrolled in MLTC.

Uniform Assessment System-NY (UAS-NY) Community Health data
The MLTC plans are required to collect and report to the DOH information on enrollees' levels of functional and cognitive impairment, behaviors, and clinical diagnoses. This information is collected at enrollment and then semi-annually thereafter. The UAS-NY is an electronic system based on a uniform data set, which standardizes and automates needs assessments for home and community based programs in New York. The UAS-NY is based on the interRAI suite of assessment instruments. interRAI is a collaborative network of researchers in over 30 countries committed to improving health care for persons who are elderly, frail, or disabled. Their goal is to promote evidence-based clinical practice and policy decisions through the collection and interpretation of high quality data. The interRAI organization and its assessment tools are used in many states, as well as Canada and other countries. Using the UAS-NY tool facilitates access to programs and services, eliminates duplicative assessment data, and improves consistency in the assessment process. With the UAS-NY, functional status datademonstrates its importance to inform eligibility for the MLTC program, provide the basis for the MLTC plans' care management planning processes, and facilitate a plan's identification of areas where the patient's status differs from optimal health or functional status.
Assessment data are submitted by plans to the UAS-NY electronically as assessments are conducted, and are added to the database upon submission. Each year, MLTC UAS-NY submissions are created into two static assessment files. One containing the most recent assessment for enrollees in each plan from January through June. The second containing the most recent assessment for enrollees in each plan from July through December.These two files will be used to describe and evaluate the HCBS expansion population performance once in a MLTC plan.

Minimum Data Set (MDS 3.0)
New York has access to the federal standardized assessment data of nursing home residents. Following CMS'episode logic, assessments are linked and length of stay will be evaluated for transitioned individuals.

ATTACHMENT H
Mainstream Medicaid Managed Care Data Table

Goal 1: To increase access to health insurance through Medicaid enrollment

	Research Questions	Hypothesis	Measures/Variables	Measure Steward	Data Sources
1	How many recipientsare enrolled through Express Lane-like Eligibility?	The number of recipients enrolledthrough this mechanism will remain steady through the waiver period.	Total enrollment andpercentage of total Medicaid enrollmentthrough Express Lane eligibility, calculated monthly and annually over the waiver period.	DOH	Medicaid Data Warehouse NYSoH Enrollment Files
2	Are there differences in the demographic and clinical characteristics ofMedicaid beneficiaries enrolled through Express Lane-like Eligibility as compared to those not enrolled through this mechanism?	Differences in demographic andclinical characteristics of Medicaid beneficiaries should be similarin patterns seen for other types of Medicaid enrollment mechanisms.	Comparison of Medicaid beneficiaries enrolled through Express Lane-like Eligibility and those not enrolled through this mechanism, stratified by demographic (age, sex, race/ethnicity, region) and clinical (presence or absence of chronic disease such as mental illness, diabetes, maternal condition/delivery).	DOH	Medicaid Data Warehouse NYSoH Enrollment Files
3	What portion of the beneficiaries enrolled through express lane eligibility were later deemed to be ineligiblefor coverage?	Because the eligibility levels forreceiving TA are lower than for Medicaid only, it is unlikely that many beneficiaries will be retroactively ineligible.	Once indicators are available for tracking, enrollment under Express-lane eligibility can be measured; disenrollment numbers can also bemeasured and stratified by method of enrollment.	DOH	Medicaid Data Warehouse NYSoH Enrollment Files

Goal 2: To limit gaps in Medicaid eligibility due to fluctuations in recipient income

	Research Questions	Hypothesis	Measures/Variables	Measure Steward	Data Sources
1	What is the distributionof enrollees within select continuous enrollment cohorts?	Months of enrollment per member will show an increase over the five (5) years following the implementation of 12-month continuous eligibility as compared to the five years preceding its implementation. Similarly, the number of enrollees with 12 months continuous enrollment will show an increase over the five years preceding implementation.	The mean months ofenrollment per member will be calculated for each of the selected time periods.	DOH	Medicaid data warehouse NYSoH EnrollmentFile
2	Does continuous enrollment differ by demographic or clinicalcharacteristics?			DOH	Medicaid data warehouse NYSoH Enrollment Files
3	Did Medicaid's average months of continuous enrollment increase following the implementation of continuous eligibility as compared to pre-implementation?	Months of enrollment per member will showan increase over the five years following the implementation of12-month continuous eligibility as compared to the five (5) years preceding its implementation.	The mean months ofenrollment per member will be calculated for each of the selected time periods.	DOH	Medicaid data warehouse NYSoH Enrollment Files

4	Was there an increase in the percentage of Medicaid beneficiaries continuously enrolled for12 months following implementation of continuous eligibility as compared to pre-implementation?	The percentage of members with 12- months continuousenrollment will increase following the implementationof 12-month continuous eligibility as compared to the five (5) years before its implementation.	The proportion of enrollees continuously enrolled over a 12- month period will be calculated for each of the time periods inthe evaluation period.	DOH	Medicaid data warehouse NYSoH Enrollment Files
5	How do outpatient, inpatient and emergency department visits compare pre- andpost-implementation of this policy? How have costs been impacted because of the changein utilization?	The use of primarycare and other preventive services will increase following the implementationof 12-month continuous eligibility because of continuity of coverage resulting from the initiative.	To compute per member per year rates for each of these services, the total number of primary and preventive care services each year will be determined, and divided by the total number of months of enrollmentover all recipients for that year and the resulting quotient multiplied by 12.	DOH	Medicaid data warehouse NYSoH Enrollment Files
6	How many of the beneficiaries coveredunder continuous eligibility would have been ineligible for coverage if not for the waiver?	The number of enrollees who would have been ineligible will be low, given the lackof requirement to report changes in income.	Enrollee reported changes in incomewill be used to calculate potential loss of eligibility, regardless of whether eligibility isactually lost.	DOH	Medicaid data warehouse NYSoH Enrollment Files

Data Sources

Medicaid Data Warehouse
This robust dataset includes enrollment and eligibility data as well as claims and managed care encounters. Several 3M products are used to evaluate members' clinical risk (Clinical Risk Groups) and preventable event measures, such as Prevention Quality Indicators. These data will be used to evaluate patterns of care for the sub-populationsof interest.

New York State of Health (NYSoH) Enrollment
Since the inception of the Affordable Care Act, Medicaid enrollees who are not eligible for cash assistance enroll through the NYSoH rather than through local Departments of Social Services (LDSS). These data enrollment datawill be used, in addition to enrollment data from the LDSS, to obtain a complete picture of Medicaid enrollees.

Attachment I
Frequently Used Acronyms

Acronym	Definition
ACT	Assertive Community Treatment
ANOVA	Analysis of Variance
AOT	Assisted Outpatient Treatment
APC	Advanced Primary Care
ADHD	Attention-Deficit/Hyperactivity Disorder
BH	Behavioral Health
BPD	Borderline Personality Disorder
CACS	Consumer Assessment of Care Survey
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CBP	Controlling High Blood Pressure
CMH	Community Mental Health
CMHA	Community Mental Health Assessment
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CPST	Community Psychiatric Support and Treatment
CSC	Coordinated Specialty Care
CVD	Cardiovascular Disease
DD	Difference in Difference Design
DOB	Date of Birth
DOH	New York State Department of Health
DSRIP	Delivery System Reform Incentive Payment
DUA	Data Use Agreement
ECHO	Experience of Care and Health Outcomes
ED	Emergency Department
EHR	Electronic Health Record
ER	Emergency Room
EQRO	External Quality Review Organization
FEP	First Episode Psychosis
FFS	Fee for Service
FTE	Full Time Equivalent
FUA	Follow-up After ED Visit for Alcohol and Other Drug Dependence
FUM	Follow-up After ED Visit for Mental Illness
GAF	Global Assessment of Functioning
GLMM	Generalized Linear Mixed Model
HARP	Health and Recovery Plans
HCBS	Home and Community Based Services
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	United States Department of Health and Human Services
HIV	Human Immunodeficiency Virus
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
IMPACT	Improving Mood – Providing Access to Collaborative Treatment
IP	Inpatient

MAT	Medication-Assisted Treatment
MCO	Managed Care Organization
MHARS	Mental Health Acute Response Service
MHSIP	Mental Health Statistics Improvement Program
MIRECC	Mental Illness Research, Education, and Clinical Center
MMC	Medicaid Managed Care
NIMH	National Institute of Mental Health
NYC	New York City
NYS	New York State
DOH	New York State Department of Health
NYSoH	New York State of Health
OASAS	New York State Office of Alcoholism and Substance Abuse Services
OMH	New York State Office of Mental Health
OTNY	OnTrackNY
PCMH	Patient Centered Medical Home
PCS	Perception of Care Survey
PMPM/Y	Per Member Per Month/Year
PPS	Performing Provider System
PROS	Personalized Recovery Oriented Services
PSM	Propensity Score Matching
PWI-A	Personal Wellbeing Index adult version
QARR	Quality Assurance Reporting Requirements
RAISE	Recovery After an Initial Schizophrenia Episode
RAISE-IES	Recovery After an Initial Schizophrenia Episode Implementation and EvaluationStudy
RFP	Request for Proposals
ROS	Rest of the State
SDC	Self-Directed Care
SEES	Supported Education and Employment Specialist
SMI	Serious Mental Illness
SNP	Special Need Plan
SSI	Supplemental Security Income
SUD	Substance Use Disorder
UAS	Uniform Assessment System
VPN	Virtual Private Network