Enrollment Center Q and A's 226-666
January 15, 2009

Funding

226) Q: The RFP states that the Department intends to award $34 million, subject to available funds. It also states that the contract term is 5 years with the potential of a 2 year option. For what period of time is the $34 million allocated?

Answer: It is allocated for year one. There will be an additional allocation for each succeeding years.

227) Q: Please provide current organizational charts.

Answer: Please see Attachments 1 and 2.

Eligible Applicants

228) Q: The State requires experience operating a statewide enrollment center for Medicaid or SCHIP. In lieu of this experience, will the State accept experience operating a statewide enrollment and/or billing center for other state health care programs.

Answer: Please see the first set of questions and answers issued on December 8, 2008. The State will not accept experience other than in operating a statewide enrollment center for Medicaid or SCHIP.

Statewide Call Center

229) Q: Which upstate, downstate and LDSS lines comprise the Medicaid Hotline that the Department currently operates?

Answer: The Medicaid hotline currently includes the following, which will be subsumed by the Call Center:

Program/Application	Telephone #
OHIP	877-678-3728
OHIP- MEDICAID COPAY	800-541-2831
OHIP - MEDICAID FRAUD	877-873-7283
OHIP - NEWBORN	877-463-7680
OHIP - PHARMACY	877-309-9493
OHIP - PRESUMPTIVE ELIGIBILITY	888-375-1912

The current additional hotlines include, and will be subsumed by the Call Center:

OHIP FAMILY HEALTH PLUS	877-934-7587
CHILD HEALTH PLUS	877-898-5849
CHILD HEALTH PLUS	800-698-4543

230) Q: What is the current staffing model and costs per Full Time Employee (FTE), please include FTE skill set and cost variances? Is there a cost variance for multilingual capabilities?

Answer: In total, the call centers employ 68 full-time and 10 part-time employees. Medicaid pays a premium for multilingual hotline staff. Please note an error in the first Q and A document in questions 49 and 52. The number 58 should be changed to 68.

231) Q: Please provide performance audits and corrective action plans for each of the call centers.

Answer: The current CHPlus hotline has always met the performance standards of the contract and there has been no need to review a corrective action plan. Medicaid hotline supervisors evaluate employee performance, and provide corrective action if needed. Current performance audits for the Family Health Plus hotline are performed by the Office of the Commissioner, Management Analysis and Project Services (MAPS).

232) Q: What will happen to the other centers and are those staff members available for recruitment?

Answer: The other centers will no longer provide these services. We expect the staff would be available for recruitment, bearing in mind that only the current CHPlus hotline provides the level of services that will be required of the new Call Center. This means that most of the staff will have a significant learning curve.

233) Q: Are any of the staff of the call centers permanent or temporary State employees? In addition, do any of the Contractors utilize temporary employees? If so, how many permanent State staff, temporary State staff, and temporary contract staff are utilized at each call center?

Answer: The CHPlus hotline is staffed by the vendor directly with both full time and part time employees; there are no State employees. The FHP hotline includes no State staff. The staff for the Medicaid hotline includes State and temporary employees. Bidders should determine the number of staff needed to have sufficient expertise with the requested services outlined in the RFP.

Hotline	# State Employees	# Contract Employees	Full –Time	Part-Time
CHPlus	0	17	10	7
Medicaid	3	28	28	3
FHPlus	0	30	30	0

234) Q: The Department operates three separate hotlines for Medicaid, Family Health Plus, and Child Health Plus applicants and enrollees. Are private Contractors operating any of the three existing hotline call centers? If yes, how will the State normalize pricing from other bidders? Where is the call centers currently located? Will the Department provide contract copies for any private Contractors currently operating these lines?
Q: Is the Department going to normalize for the costs of locating operations in New York City Name and addresses of all current NY call centers and their subcontractors including hours of operation. Same information for State operated call centers.

Answer: Medicaid Hotline: located in Riverview Center, Menands, NY. Hours of operation are Monday through Friday 8:00 AM – 4:45 PM. Administered by New York State, Department of Health.
Family Health Plus Hotline: located on W.A. Harriman Campus, Albany, NY. Hours of operation are Monday through Friday 8:00 AM – 5:00 PM. Administered by New York State Department of Taxation and Finance
Child Health Plus Hotline: Administered by Automated Health Systems, Inc. located at 300 Arcadia Court, 9370 McKnight Road, Pittsburgh, PA 15237. Hours of operation are Monday through Friday from 8:00 AM to 8:00 PM and on Saturday from noon to 5:00 PM.

The RFP will be scored uniformly for all bidders. Please see the Cost Work Sheet Section, p. 51 of the RFP.

235) Q: Are these other call centers outsourced or state agencies?

Answer: The Medicaid hotline is run through the Department of Health. The Family Health Plus hotline is contracted out to be run by the Department of Taxation and Finance. The Child Health Plus hotline is outsourced to a private company.

236) Q: Please provide statewide Call Center scripts used by each call center today.

Answer: See Attachment 6 of Round 1 Q and A's.

237) Q: Please provide contract amendments or description of work add-ons for the current call center contracts and service level agreements for each contract.

Answer: We have not modified the original contract for the Child Health Plus hotline.

238) Q: Do you have encryption capabilities for email exchange with subcontractors?

Answer: Yes, through the Department's Health Provider Network.

239) Q: Describe your vision for the consolidation of several call centers into this new centralized call center.

Answer: Please see the RFP

240) Q: Please provide current Contractors' training plans.

Answer: The current CHPlus Contractor utilizes an extensive orientation and training curriculum based upon a structured initial training period (two weeks); ongoing training and regular refresher training sessions and an ongoing dialogue between customer service representatives, supervisors and managerial staff.

The Medicaid hotline training is a one to two week process of on the job training through observation. Staff begins taking calls when determined appropriate and use the scripts provided.

The Family Plus Health Hotline conducts a half day training for the new employees using a combination of the call scripts and database training where answers to FAQ's and other general information can be found.

- Call scripts are in attachment 6 of Round 1 Q and A's.

241) Q: Are there plans to leverage and re-use any of the existing infrastructure and systems that they are using (if any)?
Q: Will any call center assets (space, IVR, ACD, terminals, etc) be assumable by bidder?

Answer: No.

242) Q: What percentage of calls must be recorded? How long must they be archived?

Answer: The current hotlines are not required to record calls as they are not doing renewals, and it is not critical to record the information they are providing. We are not requiring recording for the centralized Call Center. We are, however, requiring that 25% of telephone renewals be recorded. The length of time the Contractor will be required to archive these recordings depends on whether or not the enrollee has requested a fair hearing. We will work out the details with the Contractor.

243) Q: Who currently provides your phone service and maintenance?

- How often and what type of service do you require on your phone lines?
- How many phone ports do you currently use to handle call volume?

Answer: Verizon has the contract with the State for the Family Health Plus and Medicaid hotlines. Avaya is the equipment provider, and currently Medicaid has 33 ports. This information is unavailable for the CHPlus hotline as the current vendor considers this information to be proprietary.

244) Q: Please provide an inventory of the current phone numbers to be managed."

- Which upstate, downstate and LDSS lines comprise the Medicaid Hotline that the Department currently operates? Please provide an inventory of the current phone numbers to be managed?
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Answer: See answer to 229. The Contractor will manage the current CHPlus, Family Health Plus and Medicaid hotlines. There are several other numbers that feed into the Medicaid hotline, such as the Newborn Hotline and the Presumptive Eligibility Hotline. We are not certain whether we will have one new public number or one of the three main numbers that all others will feed into.

245) Q: What languages are required for the call center and for the renewal function?

Answer: The Contractor must be able to communicate with all who call the Call Center for information and all who call to recertify. As the RFP notes, the Contractor must offer assistance in English, Spanish, Russian, Arabic, Haitian Creole, Cantonese and Mandarin. Enrollment Center staff who speak English and/or Spanish must be available, at a minimum, during all hours of operations. A translation services must be available for languages not offered by the Enrollment Center staff.

246) Q: Please provide the name of current language translation service vendors used for each call center or name of state preferred translation vendor.

Answer: The CHPlus hotline utilizes Spanish speaking customer service representatives (CSR) on staff. It utilizes the toll-free Language Line Services (1-800-752-6096) to obtain translation services for other languages. The Medicaid hotline utilizes Spanish speaking customer service representatives on staff (average of 5 -7) at any time. InterpreTalk language line is used for other languages, (1-800-305-9673). The Family Health Plus hotline also utilizes InterpreTalk as a language line service.

247) Q: Please provide Call Center reports for each call center for last 12 months to include: volume of calls received, reasons for calls, abandonment rates, average speed to answer, and average talk time.

Hotline	Average Calls/Month	Maximum Calls in One Month	Minimum Calls in One Month	Abandonment Rate
Child Health Plus	12,274	17,424	7,734	2.7%
Family Health Plus	5,617	9,736	3,167	Unknown
Medicaid	57,242	68,338	50,943	17%

Answer: On average, 63% of the Child Health Plus calls are general inquiries. The remainder are: 18% requesting mailings, 6% requesting applications, 5% are calls transferred internally, and the remaining 8% are complaints, incident reports, renewals or voicemails.

On average, the Medicaid hotline answers calls within 55 seconds, with an average of 92% of calls answered. The wait time before a call is abandoned averages one minute, thirty-nine seconds. The average length of a phone call was one minute, forty-nine seconds.

248) Q: Please provide mail volume by type of item for the last 12 months

Answer: For the last twelve months, the CHPlus hotline distributed 40,384 mailings that included one or more of the following types of documents: Growing Up Healthy Application (English or Spanish), Access New York Application (English or Spanish), Child Health Plus Brochure (English or Spanish), Child Health Plus Fact Sheet, Child Health Plus Renewal Form, Request for Premium Review Form, and Child Health Plus Flyer. The monthly mail volume during the previous 12 months ranged from a minimum of 1,687 to a maximum of 5,130. The average monthly volume of mail distributed was 3,365.

The Medicaid hotline only mails provider listings and has mailed an average of 2,300 listings per month for the last 12 months. Currently, the Family Health Plus Hotline does not have the responsibility for mailings.

249) Q: There are several discussions in the RFP related to mailings. It appears that some are done by the Department and others are the responsibility of the Contractor. Would the

Department provide a complete breakdown of what mailing materials are the responsibility of the Contractor and what materials are handled by the Department?
Q: Pertaining to the above question concerning mailings – Would the department provide a list of materials that compose each mailing required of the Contractor and the estimated volumes and postage costs for each?

Answer:

Contractor Responsibilities

Call Center Requested Mailings:
No set package; should include information on caller's requests or call scripts instructed items.

- Growing Up Healthy Application (English and Spanish)
- Access New York Application (English and Spanish)
- Child Health Plus Brochure (English and Spanish)
- Child Health Plus Fact Sheet
- Child Health Plus Renewal Form
- Request for Premium Review Form
- Child Health Plus Flyer

The above mailings average 3,365 mailings/month - includes any of the above mentioned items, individually or bundled. During the last twelve months, total postage ranged from $1,880 to $7,590 for these mailings.

- Provider Listings for Medicaid recipients. *Volume is 2,300 mailings per /month.*

- Outreach materials (flyers & brochures, to be created) for Premium Assistance Program, and Family Health Buy-In. *These materials are under development so we are unable to provide costs associated with them.*

Renewal Mailings (Telephone & Mail-In)
This includes all program renewals: Medicaid, Family Health Plus, Child Health Plus, Premium Assistance Program, Family Health Plus Buy-In.
- Applications and reminder notices when clock-down begins and no renewal has been completed.
- Notice for outstanding documentation requests, post telephone/mail-in renewal.
- Notice for documentation to clarify discrepancies based on RFI data or submitted documentation.

The estimated volume of renewals per month, as stated in the RFP on page 53, is 70,000 to 100,000 per month. Postage costs are unknown at this time, however, only those renewals needing additional documentation will be sent mailings.

Premium Assistance Program:
- Open enrollment outreach for current FHP recipients.

Current volume for the FHP 500,000 individuals. Volume projections are under 500,000 as couples are included. Postage is unknown, but assuming it is a two page mailing per household, the cost would be about $150,000 annually.

Department Responsibilities:

Call Center Mailings:
None

Renewal Mailings (Telephone & Mail-In)
Client Notification System:
- Renewal reminder notices for MA and FHP- 60 to 90 days before renewal due.
- Notices of eligibility denials, acceptance, or changes between programs (MA to FHP)

-Health Plans mail reminder notices 90-days in advance of renewal for CHPlus.

Premium Assistance Program:
None
Family Health Plus Buy-In Program:
None

250) Q: One of the tasks of the Enrollment Center, under "operating a single statewide call center includes providing Medicaid program information on "long term/chronic care description and eligibility requirements. What does this mean? Will it include information on the various community-based long term care programs, such as the long-term home health care program, managed long term care, assisted living, personal care, consumer directed personal assistance program, including services, eligibility requirements and how to enroll in those programs? Will it include information on institutional long term care services?

Answer: The call center will provide information on all services and programs provided under the Medicaid, Family Health Plus and Child Health Plus programs including eligibility and enrollment requirements.

251) Q: Please provide current Contractors' quality management plans

Answer: The CHPlus hotline Contractor utilizes a process-oriented continual quality improvement plan based upon established performance standards, ongoing comprehensive monitoring of workers and the project, and the ability to recognize deviations to promptly implement a corrective action plan. As part of the plan, management and supervisors will monitor calls and statistics, aggregate and review staff contact sheets and solicit feedback from consumers to determine customer satisfaction.

The Medicaid hotline supervisor does live listening on a staff of 30 people. Staff must meet performance standards. Monitoring software provides reports to the supervisor for review. The Family Health Plus hotline has a quality assurance team in place that is responsible for reviewing, scoring and follow-up coaching calls taken by staff. They meet with the staff at regular scheduled interval (weekly or bi-weekly) to go over performance.

252) Q: What is the average length of call for the Statewide Call Center?

Answer: The average call length for the past 12, months was 2 minutes and 40 seconds.

253) Q: The RFP states that the Contractor must "maintain program information materials. Does this mean that the Contractor simply must maintain inventory for fulfillment purposes and ask the Department for more when inventory is running low? Or is the Contractor responsible for printing

the materials? Do LDSS or community-based organizations order large quantities of these materials? Is there a process today whereby these materials are ordered?

Answer: The Contractor will order materials from the Department's Distribution Center. The Contractor should maintain an inventory of those materials needed by the Contractor to operate the Enrollment Center. Most materials will be needed for the Call Center. The Contractor will not be responsible for printing materials except in very rare circumstances and in relatively low volumes. The rare circumstance may be a delay in the Department's printing leading to a shortage of material.

254) Q: The Contractor must maintain program information materials and applications in adequate numbers to accommodate requests from prospective employees." Please define "adequate numbers."

Answer: The Contractor should maintain at least 20,000 applications at a time to send to prospective enrollees.

255) Q: Is postage for mailing out documents/materials cost reimbursable?

Answer: All costs should be included in your per unit pricing.

256) Q:"The Department may require some written materials to be maintained in audiotape format for the low literacy and vision impaired population." Does that mean audiotape format only, or does the Department envision requiring the Contractor to produce other types of media materials?

Answer: The Department meant audiotape format only. However, we are open to suggestions from bidders about other media that works well in your experience with the low literacy or vision impaired population.

Renewal

257) Q: Please provide the procedure manuals for eligibility and renewal processing.

Answer: Please see the following hyperlink to access the Medicaid Rules (Medicaid Reference Guide): http://www.health.ny.gov/health_care/medicaid/reference/mrg/

258) Q: Please provide sample letters used to communicate eligibility status or other standard letters.

Answer: All letters regarding eligibility status and other standards letters will be disseminated through the Client Notice System (CNS), as opposed to the Enrollment Center. We are therefore, not providing them at this time, and will work with the successful bidder to develop any materials that they will be mailing to applicants or enrollees on behalf of the State.

259) Q: Will the eligibility screening tool be built as a part of the Department's expanded EEDSS eligibility interview question set?
Q: Is the Enrollment Center Contractor expected to supply the eligibility screening tool? Is the screening tool different from the renewal tool described on page 16 of the RFP?
Q: Is there a similar sort of interface [renewal tool interface for eMedNY and WMS] that will be built into the renewal tool for KIDS, or will it just be direct access and you'll need to work through that separate system for updates to the system?

Answer: The system we are building is new and will not be tied to the conventions of the old WMS or EEDSS. It will be a modular, modern, table driven, flexible system using new technology. It will be designed so the functionality can be expanded more readily as the Enrollment Center grows and as we expand features out to the public.

During year one, the Contractor will likely access KIDS directly for transition cases; however the remainder of renewals will be entered into the renewal tool directly. Our intent is to have KIDS data entry through the renewal tool.

260) Q: Would EEDSS be used to add new household members?

Answer: The renewal tool will be used to add new household members.

261) Q: What about if a member of the household turns 21 – would we then refer that household member to the LDSS?

Answer: No. The Contractor will use the renewal tool

262) Q: Would EEDSS be used to identify the changes in eligibility discussed on pg. 22 of the RFP?

Answer: The renewal tool will be used for this.

263) Q: As for training capability that you [the Department] have and that you'll be providing training; will the same be said of KIDS?

Answer: Yes

264) Q: How many State staff do you envision the Enrollment Center having to house?

Answer: The decision about state staff is under discussion. The Department will work with the Contractor on the best strategy to ensure that eligibility determination is completed by the State, building on the Contractor's experience in other states. For purposes of the proposal, bidders should budget for a desk and computer for five State staff.

265) Q: What will their role be then specifically at this time?

Answer: Federal regulations require that state employees make a final eligibility determination for Medicaid. That is not the case for SCHIP. The actual operations of this function are still under development and we will entertain viable options in consultation with the vendor. At this point, we thought it made sense to co-locate some state staff with Enrollment Center staff to do this supervisory and final authorization function.

266) Q: In the Enrollment Center process it asks the Contractor to propose a process for ensuring they do not renew enrollees that have already been renewed through the LDSS or health plan. Can you provide more information about the systems that the LDSS or health plan would populate with the information that they have completed those renewals?
Q: The first paragraph discusses the communication developed between the Contractor and the LDSS offices. The wording seems to indicate that something is already in place. Does someone do this now? – "In the Enrollment Center process it asks the Contractor to propose a process for ensuring they do not renew enrollees that have already been renewed through the LDSS or health plan. Can you provide more information about the systems that the LDSS or health plan would populate with the information that they have completed those renewals?"

Answer: The Enrollment Center staff will be required to check against WMS to ensure that the renewal hasn't been completed.

267) Q: These three sections discuss multiple ways the Contractor is to enter enrollment information. In one instance, enrollment is entered directly into WMS or KIDS, for other cases the Contractor is to notify the appropriate health plan, and on page 34, coordination with the State's Enrollment Broker is required. Would the Department provide further clarification as to the Contractor's responsibility for the entry of enrollment/renewal information, especially as it relates to interaction with the Enrollment Broker?

Answer: The Contractor will not enter information directly into WMS, but rather will enter information into the renewal tool. For Child Health Plus, the Contractor will enter information directly into KIDS. Please see the section on Managed Care for further details on the role of the Enrollment Center regarding managed care health plan selection and interacting with the Enrollment Broker.

268) Q: It states that the Contractor shall review all applications for completeness including documentation. What does this documentation typically consist of? What are the typical documentation requirements at renewal.

Answer: The EC will only renew those enrollees who are permitted to attest to their income and residency. By definition, these enrollees have few documentation requirements. Documentation

may be required if an enrollee's immigration status has changed, they have obtained health insurance, or if information from RFI is materially inconsistent with the self-attested information.

269) Q: Will LDSS employees play any role in the renewal process for the areas of the state that are incorporated in the centralized renewal model?

Answer: The LDSS will play a role in the renewal process for all those who cannot self-attest to their income, including those who are receiving long term care.

270) Q: Is the 100,000/monthly renewal number meant to be a base number to be built upon later?
Q: What percentage of the 100,000 renewals currently processed are from those individuals that cannot self-attest and, accordingly, would not be handled by the Contractor?
Q: What is the volume of mail renewal? What is the volume of phone renewals? What is the average talk time to complete a phone renewal.
Q: The RFP mentions with the combined programs there are about 100,000 renewals a month; is that cases or individuals?
Q: How big is the self-attest population?

Answer: The 100,000/monthly number is an estimate of the number of monthly case renewals for those who can self-attest (1.2 million cases per year). As telephone renewal is a new initiative, we do not know the number of people who will renew by phone, or the average talk time of a telephone renewal.

271) Q: What percentage are mail-in renewals?

Answer: At least 90% of attesters renew by mail.

272) Q: Could the Department please provide the following information:

- The number of staff used by the current vendors.

Answer: This is a new initiative

273) Please provide any organizational charts submitted by the current vendors.

Answer: Renewals are currently handled by 58 local Departments of Social Services and HRA in NYC.

274) Q: Is there an electronic or paper repository of application/renewal data that must be converted to the new vendor's system.

Answer: No.

275) What is the volume or number of documents to be converted?

Answer: N/A

276) What is the current format of any electronic documents that need to be converted to a new vendor's system.

Answer: N/A

277) Q: What are estimates of the number of renewals falling under each special circumstance? Q: The RFP lays out a number of special circumstances that arise during renewal processing. Can the Department provide information on the historical frequency of each of the different special circumstances listed? Are there written procedures already established for each of these circumstances beyond this Request? Can the Department provide access to those procedures?

Answer: Numbers below are not exclusive or additive. A case may involve more than one special circumstance; e.g., a new member joins the household and the enrollees change programs.

Changes in Household Size and Composition

i) new members join household: <10%
ii) member of household is deceased or moves out of household: <5%
iii) member of household has turned 21 <10%
iv) household member is pregnant <1%
v)

Change in Residence, Program Eligibility and Health Plan Enrollment

vi) family has moved to another county <5%
vii) enrollees are changing programs <5% (higher if/when eligibility rules change)
viii) enrollees who change health plans at renewal <5%

Answer: See **08ADM-04** on the Department website, at http://www.health.ny.gov/health_care/medicaid/publications/pub2008adm.htm and/or the Medicaid Reference Guide at http://www.health.ny.gov/health_care/medicaid/reference/mrg/,

278) Q: Please provide more specific information on the phase in of this process, including the expected date of full implementation, and a monthly expectation of renewals until that date.

Answer: Please see responses provided to the Q and A's posted on December 8, 2008. Since this is a new initiative, the cost of which is uncertain, the first year will focus on the Call Center and the Renewal function. Those projects will start when the Contract is executed.

The RFP listed the main areas of responsibility for the Enrollment Center and the start up time for each of the functions. The Call Center has a three month start up period and must be implemented statewide after that period of time. The Renewal function (phone and mail) will have a six month start up period. Start up periods will begin with the contract execution date.

It is the State's goal that the renewal function be implemented statewide as soon as possible; however, we expect to phase it in based on available resources. We will collaborate with the Contractor on the phase-in but the current thinking is that one or a small group of counties will go live to test the system followed by another group of counties up to the full budgeted amount. At least one borough in NYC will be included in the initial phase-in after the testing stage.

Once these functions are implemented, additional projects will be phased in, subject to availability of funding.

279) Q: Does the Department anticipate that the counties comprising NYC will be phased in at one time?

Answer: No. At least one borough in NYC will be included in the initial phase-in.

280) Q: Is a system of renewal tracking to be a vendor provided system?

Answer: Yes.

281) Q: Can you provide the average length of time it takes to process a MA/FHP renewal application through the appropriate systems?

Answer: Less than 30 minutes for a renewal package that is complete.

282) Q: Can you provide the average length of time it takes to process a CHPlus renewal application through the appropriate systems?

Answer: One of the largest CHPlus health plans reports they process 4 to 6 applications per hour.

283) Q: How will ADMs and other regulatory changes be conveyed to the selected Contractors?

Answer: The State will convey all changes to the Contractor either electronically or in writing that are relevant to the EC.

284) Q: If the RFI and the applicant supplied data disagree, is manually supplied documentation what should be used to resolve the conflict? How current is the information in the RFI?

Answer: If the RFI or other information does not reflect what the person said in the telephone renewal or wrote on the web-based application, the Enrollment Center must obtain updated documentation from the enrollee if the discrepancy is material to the eligibility determination. The RFI information is generally lagged by one quarter.

285) Q: How often are databases updated with new information on potential enrollees? For example, what if a person sends an application after losing employment or receiving a lower salary?

Answer: In the instance where a person's income or other information changes such that the RFI indicates an income that no longer reflects current income, the person should alert the EC to their new information so that the system can be updated

286) Q: Is the Enrollment Center responsible for tracking each renewal that has been sent to a state employee for final approval and notifying the relevant state employee(s) when the renewal has not been acted upon?

Answer: Yes.

287) Q: How does the Enrollment Center know when the state employee final eligibility disposition has occurred?

Answer: At a minimum, the disposition will appear on WMS.

288) Q: Is the Contractor's responsibility completed when a renewal transaction is sent to a state employee or is it when the final eligibility determination is complete?

Answer: The Contractor will be expected to track renewals to completion. If the case must be referred to the local district, the Contractor's responsibility generally will end, unless documents arrive after referral that the Contractor must forward to the LDSS.

289) Q: How quickly can the Contractor expect that State employee supervisory approval will be performed? Are their expected turnaround times (e.g., 24 hours, one business day, two business days from receipt by the State employee, etc.) for the State employees to process these renewals?

Answer: This depends on the quality and quantity of renewals processed by Contractor staff in any given day.

290) Q: The last paragraph in this section discusses the submission of the case to the Department for review and final eligibility determination. Will the Department please provide a detailed description of how this process works?

Answer: As this is a new initiative, the processes will be developed and are not yet available.

291) Q: If the EEDSS system currently does not include the capability to route renewals to state workers for approval, does the Department have any work flow processing system?

Answer: Initially workflow will be accomplished manually, should the renewal tool not include electronic routing.

292) Q: What is to be done with returned mail, address, unknown and forwarded mail information?

Answer: If there is a forwarding address, the mail is forwarded. Otherwise, if there is no secondary contact information for a client representative, a closing notice would generally be sent to the last known address

293) Q: What is the preferred schedule for sending renewal reminders?

Answer: To be determined.

294) Q: What are the reminder and missing information notices generated for CHPlus members currently?

Answer: Each plan communicates with those enrolled in the plan. Mailings include notice of renewal due, follow-up letters requesting additional information if necessary and notices of disenrollment.

295) Q: Per the RFP, LDSS and the Health Plans will still have the ability to process renewals sent to them. Would the Department consider requiring LDSS and the Health Plans to send them to the Enrollment Center in order to support a centralized process?
Q: The enrollee will be asked if he/she has tried to renew by mail or telephone or through the LDSS. What form of documentation of this inquiry is required by the Department?

Answer: Enrollees able to renew through the EC will be told to call or mail back the renewal to the EC. However, a few may go directly to the local district. If a local district receives a client renewal, we expect the district to process it. A method to communicate this information will be devised.

The Enrollment Center will be trained and is expected to follow the state designed application and protocol. There is no specific documentation required of the EC on this question.

296) Q: What is the current average interview time for initial applications and for renewals?

Answer: The interview time at initial application ranges from 30 to 60 minutes. Interviews are only done at initial application, not at renewal

297) Q: Please provide the estimated processing time for a mail-in renewal and the estimated processing time for a telephone renewal.

Answer: We expect that it will take less than 30 minutes to process a complete mail-in renewal. However, currently the process can take more time from start to finish if it is necessary to obtain documentation. With telephone renewal being a new initiative and those being processed by the EC being self-attesters, we do not know what the processing time will be, but expect it to be faster.

298) Q: This subsection briefly describes the Resource File Integration (RFI) subsystem of WMS. But elsewhere in the RFP, the Department talks about third-party database verifications that appear to go beyond the RFI capabilities. Please identify any renewal documentation or verification that the State wishes to obtain through a third-party database that it cannot currently obtain through RFI.

Answer: Examples include additional financial data matches, including out-of-state property, more current employment information, third party insurance coverage, and the like.

299) Q: How will the Enrollment Center Contractor's responsibility for timely and effective renewal processing be affected if the renewal-related enhancements to EEDSS have technical flaws that prevent reliable processing of renewals?

Answer: The Contractor is not responsible if the renewal tool has a technical flaw that prevents reliable processing of renewals.

300) Q: Please describe how documentation returned to the Department is managed today?

Answer: Documentation is returned to the LDSS's. The processes vary by local district.

301) Q: Are received items scanned and processed electronically or by paper processing and filing?

Answer: Both. This varies by district.

302) Q: If separate, how many FTE currently work on renewals for each program?

Answer: We do not know this information. Renewals are not necessarily handled by a separate unit, and the organization of work varies too greatly among districts.

303) Q: How will CHPlus and Medicaid enrollees be notified when it is time to renew: by the Department, the Enrollment Center Contractor, or another entity? Will the Enrollment Center Contractor have access to the list of individuals who have been notified about renewal?

Answer: Family Health Plus and Medicaid enrollees are and will be notified by the State when their renewal is due. CHPlus enrollees are notified by health plans. The EC will be sent a file of those persons who received notification of renewal and their due date.

304) Q: This paragraph states "Another issue is the different rules for Medicaid and CHPlus that make it difficult to transition seamlessly between programs. For example, CHPlus requires questions on prior health insurance to monitor "crowd out." Medicaid requires documentation of citizenship/immigration status, while CHPlus does not. To the greatest extent possible, the Department is seeking to create more seamless transitions between programs at renewal through the telephone renewal process."

- Could the Department please clarify its expectations for the vendor performing this work. For example, is the Department expecting the vendor to verify the "prior health" information supplied by the enrollee with the private payor/insurer before deciding not to enroll the child?

Answer: No. The Contractor is expected to query about other health insurance as part of the telephone renewal.

305) Q: The Department has a requirement to track "relevant" caller information. One example is given but is there a list of desired data points that should be collected or tracked? What data points need to be captured for this requirement? Please clarify.
Q: How is 'relevant information about callers' tracked today or will this be a new added function?

Answer: At a minimum, the Contractor must collect the caller's name, phone number, address, Case Identification Number (CIN), and date of birth in order to track callers. This information is also helpful to return a call if the call is interrupted. This is a new function as telephone renewal is not currently in place.

306) Q: Is it expected that the proposal will describe an encounter-tracking solution separate from the existing leverage applications?

Answer: Yes, the bidder's proposal should include encounter-tracking as there is no existing application which tracks this information.

307) Q: What percentages of renewals currently require documentation by renewing members? This information is needed to estimate postage and material costs.
Q: How many renewals require a follow-up postage paid envelope for additional documentation?

Answer: Approximately 25% - 30% of current renewals require documentation. This cannot be assumed to continue with the EC, as the EC is only going to renew those that can self-attest.

308) Q: Please provide the Department's policies regarding the types and forms of documentation that are required to complete a renewal when self-attested data does not align with the RFI data or is otherwise determined to be inconsistent or incomplete?
Q: Can the Contractor assume that the information in the RFI is current enough to satisfy renewals or should the Contractor find other automated sources to verify applicant supplied data?
Q: Please provide the parameters that are used to determine when a discrepancy is acceptable and when it triggers documentation from the renewing individual/family. For example, if a person declares their income to be $3,000 per month and their income is actually $3,050 per month?

Answer: See **08ADM-04** on the Department website, at http://www.health.ny.gov/health_care/medicaid/publications/pub2008adm.htm and/or the Medicaid Reference Guide at http://www.health.ny.gov/health_care/medicaid/reference/mrg/

309) Q: Is the Department currently working with any other programs within the state to access eligibility data available in other state systems for use in this alternative renewal process? If so, what programs?
Q: Does the State have specific third party databases in mind to use for the alternative renewal process or would it be up to the Bidder to suggest specific sources?
Q: Would the Department permit the Contractor to use IRS-provided data to which the state has access in the eligibility process?
Q: Which third-party data bases is the Department considering for use? If a license fee exists for access, will that license be provided by the Department
Q: If the Department implemented the "alternative renewal process," please describe the Contractor's responsibilities for this new approach.
Q: Would the Contractor be compensated for automatic renewals?
Q: Would the Department specify/help the Contractor arrange use of databases to be checked for automated renewal eligibility?
Q: Would files of eligibles from TANF, Food Stamps or other programs be available to the Contractor for doing an eligibility match?

Answer: The Department is very interested in obtaining data held by other state systems for use in the renewal process. We have discussed this with the Office of Temporary and Disability Assistance, the Tax Department and others. We will continue to explore this approach and would welcome ideas from bidders in this regard. If such process is implemented, it would be built into the renewal tool. Since this is not a year one or two priority, we are unable to address the compensation issue at this time.

310) Q: How many enrollees fail to renew and would be candidates for a reminder mailing?
Q: Regarding outreach, what is the frequency and volume anticipated for these programs?
-Is this happening in any capacity today and is there benchmark costs associated with these potential programs.
Q: What are the expectations regarding follow-up with newly disenrolled members?
Q: Is the Contractor responsible for contacting newly disenrolled individuals through a mailer or proactive phone calls?

Answer: See p. 24 -25 of the RFP. The Contractor should propose other activities it has found in the past to be effective.

311) Q: What is the alternative renewal process?
Q: What is the difference between the Administrative renewal idea described in subsection (i) and the "Alternative Renewal Process" described in V.C.2.k on pg. 25?

Answer: See p. 25 of the RFP. The bidder should offer any suggestions or experience they have in the use of third-party data bases to establish eligibility. There is no difference between the two.

312) Q: Regarding the statement: "If the enrollee is eligible for CHPlus, the Center must notify the health plan:" What type of notification is expected?

Answer: The information obtained by the Enrollment Center will be made available to the health plan electronically through the Health Provider Network (HPN).

313) Q: Is the HPN a secure site?

Answer: The HPN is a secure intranet designed for health care providers. It was developed by the NYSDOH as a system for electronically exchanging health related data and information between health care provider and NYSDOH

Transitions Between Programs

314) Q: In the event of a phone-based renewal where a change in program eligibility is indicated through the call, will the Contractor be able to indicate to the caller that there is a likely change or will that only be feasible once the Department's determination is made?

Answer: The EC may alert the person that their renewal application will be reviewed and that it appears they may be eligible for a different program.

315) Q: Regarding automatically enrolling a child previously in CHPlus that now qualifies for Medicaid – The RFP states that "If child enrolled in CHPlus is determined eligible for Medicaid at renewal, the Contractor shall reenroll the child into Medicaid." – Does this mean to go into the WMS system and enroll the child? Does the eligibility change need to be validated by a Department employee?

Answer: CHPlus renewals are not being handled by the EC in the first year. Phase II of the renewal tool is expected to accommodate this situation. The case will be processed by the Contractor up to the point of eligibility determination signoff, and the final eligibility determination will be done by a State employee.

316) Q: What is the current frequency of enrollees changing programs at renewal for each of the situations described on page 22?

Answer: The overall frequency of recipients changing programs at renewal is <5%. We do not have a further breakdown.

317) Q: Will the successful bidder be allowed to open a new case?

Answer: Only if it is a spin-off of a case renewing, where circumstances have changed such that the person has aged out of the program or another change where the person is now eligible for another program. Once the case is processed by the Contractor up to the point of eligibility determination signoff, it will be transmitted to a State employee for the final eligibility determination.

318) Q: If an entire family appears to be eligible for Medicaid, or a person in the Medicare Savings Program appears eligible for Medicaid, what is the Contractor's responsibility in relation to the family's or person's completion of a new Medicaid application?

Answer: If a family is renewing, the renewal form suffices without a new application. If someone has renewed using the MSP form, and it appears that they are Medicaid eligible, the Contractor staff will contact the individual to follow up.

319) Q: What are the conditions under which the Contractor can change the Medicaid coverage for the enrollee from Medicaid to FHP? Is a state worker required in this process?

See **08ADM-04** at the Department's website at http://www.health.ny.gov/health_care/medicaid/publications/pub2008adm.htm. The case will be processed by the Contractor up to the point of eligibility determination signoff, and the final

eligibility determination will be done by a State employee, in the same manner as a case that stays within its original category.

Premium Assistance

320) Q: Please provide the procedure manuals for the premium assistance program.
Q: Are there policies and procedures related to the premium assistance program that are available?

Answer: Please see the link below to access the ADM and Attachments on the Premium Assistance Program:
(http://www.health.ny.gov/health_care/medicaid/publications/pub2008adm.htm

321) Q: How does the enrollee receiving employer based insurance receive their renewal form?

Answer: The FHP-PAP coverage is renewed in the same manner as any other Medicaid program. The recipient receives renewal form generated by CNS. Information pertinent to their eligibility is verified as part of the renewal process.

322) Q: Please provide current premium assistance bands and volume in each band.

Answer: We do not know, at this time, the level of participation for this program as it has just begun. Bidders should use the volume bands provided in the RFP to develop their proposals.

323) Q: The RFP states that "The renewal function and the Premium Assistance Program may be phased in by county, to be determined by the Department of Health and subject to the availability of funding." What will be the determining criteria used by the Department for a phase in? Should Contractors assume a phase in of some sort? If yes, what would the expected roll-out be? Alternatively, should the Contractor assume a complete implementation? Contractor cost structures will vary based on whether there is a phased approach.
Q: When will the process to determine what counties will participate in the renewal function and Premium Assistance Program begin?

Answer: The strategy for the phase-in of the renewal function and the premium assistance program are different. For renewal, during the start-up period, the Contractor should implement the tasks required for statewide renewal. Whether the program is implemented statewide in the first year depends on the availability of resources. For renewal, the phase- in will be used to control volume to ensure that available funding meets volume.

The phase-in for the premium assistance program is not based on volume. It will be based on those counties that have indicated a need for assistance in implementation. The Department expects to begin with New York City and then move to add other counties.

324) Q: Will the State and the Enrollment Center Contractor collaboratively develop an implementation plan for the phase in?

Answer: Yes.

325) Q: Will the State provide a proposed schedule and list of counties/population targeted for phasing in the renewal system and Premium Assistance Programs?

Answer: No. The State cannot do this until we determine the progress of the call center and renewal function of the Enrollment Center.

326) Q: It is our understanding that it is the Department's policy to enroll qualified eligibles with private health insurance on Fee-for-Service rather than Managed Care. Is the Department expecting the vendor to verify the private health insurance coverage supplied by the enrollee with the private insurer/payor before making this determination?

Answer: Yes. Verification of private insurance is required for enrollment in the FHP Premium Assistance Program. However, it is not a condition of eligibility for either Medicaid or FHP.

327) Q: Will this (the provision of customer support within the section on the premium assistance program) be part of the Statewide Call Center? What is the anticipated additional volume of call?

Answer: Yes. Since this is a new program, we do not know the anticipated call volume.

328) Q: In the background information of the current Premium Assistance Program in Section 3.a. the number of program members was not discussed. How many program members are currently on the PAP?
Q: How many enrollees currently participate in the Premium Assistance Program?
Q: How many people are using the Premium Assistance Program today? Does the Department expect the number of people participating to remain relatively constant or does it expect it to accumulate over time?

Answer: As of 9/30/08, there are 632 enrollees in FHP Premium Assistance Program. The Department expects the program to grow over time.

329) Q: Please explain the Department's expectations regarding Contractor reimbursement of enrollee cost-sharing expenses for a person who, upon renewal, is determined eligible for the premium assistance program.

Answer: The Contractor will use the emend HIPP program to authorize and issue reimbursements for Medicaid and FHP Premium Assistance Program enrollees.

330) Q: Regarding the requirement that the Contractor gather information to determine if an enrollee is eligible to enroll in employer insurance, including plan benefit and cost information: Is the Contractor expected to work directly with an employer to obtain this information and explain it to the enrollee?

Answer: The Contractor may work directly with the employer to gather health plan and benefit information. The Contractor may have to explain to the recipient that the recipient has a choice between more than one cost effective health plans offered by the employer.

331) Q: What is the estimated monthly volume of FHP members that will need to be disenrolled due to eligibility for the Premium Assistance Program?

Answer: The latest data we have shows about 20 people moving from FHP to FHP-PAP.

332) Q: What is the estimated monthly volume of FHP members that will require refunds for cost sharing upon enrollment into the Premium Assistance Program?

Answer: The number of monthly cost sharing reimbursements per FHP PAP enrollee will vary based on usage of medical care and the number of prescriptions filled. Premium reimbursement is generally recurring. It is entered into the system once and is automatically paid thereafter.

333) Q: Please describe the procedures and requirements related to disenrolling members from FHP and reimbursing them for cost sharing expenses.

Answer: See **08ADM-01** on the Department website, under Medicaid/Reference Guides/Library of Official Documents.

334) Q: What is the level of effort expected of the Contractor in obtaining TPL from an employer?

Answer: The client has initial responsibility for providing TPL information. If the client cannot provide it and requests the Contractor's assistance, the Contractor must make its best effort to obtain the necessary information.

335) Q: Please elaborate on the statement: "At a later time, the Contractor will accept changes in circumstances from enrollees at times other than renewal."

Answer: Recipients must notify the Department if there is a change in their circumstances; for example, addresses income, household composition, etc. The notification may be necessary between renewals. These changes will continue to be reported to the LDSS, however, the Contractor may take over some of this role in the future.

336) Q: Please clarify how non-payments for renewals determined eligible in error will be handled in terms of the 3% error rate and the invoicing process.

Answer: Please see the RFP.

337) Q: Does the Department want a formal marketing and outreach effort for the PAP?

Answer: The Department does not expect enrollment in the PAP to be large given the low rates of employer coverage among the FHP population and as such does not envision a marketing campaign on a scale equal to those of the public programs in general. However, we do envision limited print marketing materials (e.g., brochures, flyers) and perhaps radio advertising around open enrollment periods for private insurance. The bidder should propose marketing and outreach efforts for the PAP that it believes will increase enrollment, recognizing that the employer coverage must meet the cost effectiveness test before FHP will pay the premium.

338) Q: Are FHP Premium Assistance Program calls included in the estimated monthly volume of 67,500 calls?

Answer: Yes

339): Q: Can the Contractor have access to the NY TPHI system?

Answer: Yes.

340) Q: Are there any restrictions as to the communications the Contractor can have with employers?

Answer: Yes, subject to the usual confidentiality requirements of the Medicaid/FHPlus programs, **t**he Contractor can communicate with employers in order to obtain the information needed to determine if the health insurance policy is both acceptable and cost-effective.

341) Q: Who currently approves enrollment into the Premium Assistance Program?
Q: Assuming that the LDSS currently handles a majority of the PAP process, how does the state currently coordinate activities between the district and the state?

Answer: The LDSS handles the entire process. The state provides direction and system support.

342) Q: Will the Contractor be responsible for assisting Medicaid members who receive premium assistance?

Answer: Yes, as part of the renewal process. On a yearly basis, premium rates must be verified and updated in the Third Party subsystem and a cost effective determination must be made based on those new figures.

343) Q: If the Contractor is required to support the Medicaid premium assistance program, please provide detailed information regarding the responsibilities for this program area. How many program members are currently on the PAP? Does the Department expect the number of people participating in PAP to remain relatively constant or does it expect it to accumulate over time? Does the Department expect the number of people participating in PAP to remain relatively constant or does it expect it to accumulate over time?

Answer: There are several documents that provide detailed information on the responsibilities for the PAP including: **08ADM-01** on the Department website, under Medicaid/Reference Guides/Library of Official Documents; the Medicaid Reference Guide, Third Party Resources, under Medicaid/Reference Guides; and the RFP.

As of 9/30/08, there are 632 enrollees in FHP Premium Assistance Program. The Department expects the program to grow over time, but we do not expect it to be more than 1-2% of total enrollment. We estimate that currently there are fewer than 5,000 Medicaid eligibles receiving premium assistance.

344) Q: Are the current call center staff supporting the Premium Assistance Program employees of NYS DOH?
Q: Where are call center staff supporting PAP currently located?

Answer: There is no dedicated PAP call center staff. This program is supported by staff of the Medicaid helpline, who are temporary employees of the Medicaid or FHP call center, located in the Capital District of New York State.

345) Q:Does a labor organization represent the current call center staff supporting PAP?

Answer: No

346) Q: How does the Government make determinations for the PAP without the HIPP calculator?
Q: If the HIPP calculator is not available before the Contractor's responsibility commences, the current methodology will be provided by the Department. Is the current methodology automated via any software? If so, what software and will code developed be provided by the Department?
Q: Is it on target to be available at the end of 2008? Please describe the methodology for calculating effectiveness.

Answer: The HIPP calculator will not be complete at the end of 2008. The methodology used for the calculator is based on Medicaid claims data within the MMIS System.

Currently, local districts use a manual worksheet and an Excel spreadsheet to determine FHP PAP cost effectiveness. For Medicaid enrollees entitled to premium reimbursement, LDSS compare the premiums to managed care rates. See **08ADM-01, Attachment D,** on the Department website, under Medicaid/Reference Guides/Library of Official Documents.

347) Q: Will the HIPP be adapted by the Department to include CHPlus when the PAP program is implemented for CHPlus or will the Contractor be responsible.

Answer: The CHPlus PAP will be materially different from the FHP PAP. The program design is simpler and does not require the HIPP calculator. Any tools required to be used by the Contractor will be developed by the Department.

348) Q: What is the status of the Health Insurance Premium Payment calculator?
Q: What is the status of the Department's creation of a Health Insurance Premium Payment calculator? What technology is the calculator built on? Can this calculator be accessed via a web-services interface?
Q: The Health Insurance Premium Payment calculator that's under development, what's the status of that? Can you describe sort of where you are in the process and what you expect out of that?
Q: So will you [the Department] be able to go ahead and prove that methodology for the Contractors before we bid?

Answer: It is under development. It is in the eMedNY queue for programming. We expect that by the time a contract is executed between the Contractor and the State, the tool will be available. When the HIPP calculator is complete, the Contractor will have access to it via the eMedNY Third Party subsystem. Currently, we have supplied the LDSS offices with the methodology (see 08ADM-01, Attachment D) so they may do the calculation by hand. That will be available to the Contractor if the HIPP calculator is not available.

349) Q: Are FHP Premium Assistance Program renewals processed annually?

Answer: Yes

350) Q: What is the estimated volume of FHP Premium Assistance Program evaluations for cost-effectiveness that the Contractor will conduct each month?
Q: Please provide the estimated monthly volume of FHP Premium Assistance Program renewals that the Contractor will process during each year of the contract.

Answer: The program began in January 2008 so there have not been any renewals yet.

Currently there are approximately 600+ enrollees in the program. Please use the volume assumptions provided in the RFP.

351) Q: Please provide the estimated volume of reimbursements that the Contractor will issue to FHP Premium Assistance Program members each month for each year of the contract.
What is the expected volume of receipts and claims to be paid?

Answer: The usual method of premium payment for employer coverage is to reimburse the member for a payroll deduction taken by the employer. However, it is also possible to pay the employer or insurer directly if that is what the employer/employee wishes. FHP-PAP currently has 632 participants with 632 monthly premiums.

The number of monthly cost sharing reimbursements per FHP PAP enrollee will vary based on usage of medical care and the number of prescriptions filled. Premium reimbursement is generally recurring. It is entered into the system once and is automatically paid thereafter.

352) Q: This section references collection of premiums from employers within a required time frame for the premium assistance program. What is the total dollar value collected from employers since January 2008? What is the standard time frame applied to the collection currently?
Q: What is the timeframe required to collect premiums from employers?

Answer: Premiums are not collected from employers for FHP-PAP. They may be collected for the FHP Buy-In. They would be paid to employers in PAP, as well as to carriers and individuals.

353) Q: The RFP states that the FHP Premium Assistance Program will pay or reimburse the employee share of the premium. Is the Contractor required to issue premium payments to employers?
Q: If the Contractor is required to issue premium payments to employers please describe the process that the Contractor will follow to do so.
Q: Is the Premium Assistance Program premium paid directly to the health plan or to the Enrollment Center?
Q: The RFP states that the Contractor will collect premiums from employers. Was this intended to say collect premium information from employers?

Answer: The Contractor is not required to reimburse an employer. Depending on each situation, the Contractor may reimburse the employer, the employee or provider. Usually it depends on the arrangement preferred by the employer; which most often means reimbursing the recipient.
If the payment is to go to the employer, the Contractor will authorize a payment to an employer. The eMedNY system will transmit the payments.

354) Q: What is the estimated volume of FHP Premium Assistance Program evaluations for cost-effectiveness that the Contractor will conduct each month?

Answer: Currently the number is less than 10 per month statewide. Future numbers are expected to be higher. Bidders should use the volume estimates in the RFP since the current enrollment is not a predictor of expected enrollment.

355) Q: Please provide the estimated monthly volume of CHPlus premium assistance program evaluations for cost-effectiveness that the Enrollment Center will handle each month upon program implementation for each year of the contract.

Answer: The CHPlus premium assistance program requires a waiver from CMS unless the SCHIP reauthorization bill simplifies the guidelines for premium assistance programs. The estimated volume, once implemented is 1-2% of program enrollment, or 300-500 per month. The program is designed to be much simpler than the FHP PAP in that there is no wrap around coverage and no reimbursement for copayments and deductibles. The Contractor will need to ensure that the employer insurance meets the minimum benefit requirements. There is no cost-effectiveness test because eligible families would be given a flat amount toward the cost of family coverage.

356) Q: What is the nature of the current fraud detection efforts and methodologies in the context of this program? Is it retrospective or prospective?

Answer: Each health plan has its own fraud and abuse program as required by the state. Fraud detection is essentially the same for this program as for others. The Contractor will be expected to reconcile information that appears to be inconsistent or incomplete before renewing a case. However, the Contractor is not expected to conduct a fraud investigation. If a case appears to involve fraud, the Contractor will have instructions on referring it for investigation. Sometimes, evidence of fraud turns up after a case has been authorized; if confirmed, the LDSS or the State then takes appropriate recovery action.

357) Q: How many households are in FHP and therefore would receive the annual mailing?
Q: What is the anticipated volume of mailings?
Q: How many households are in FHP and therefore would receive the annual mailing?

Answer: There were approximately 479,000 individuals and approximately 350,000 separate households in FHP as of November 2008. The current plan is to mail materials about the premium assistance program in the fall of 2010 or 2011 to coincide with employer open enrollment periods. This will be a one time mailing. Depending on the success of this approach, it may or may not be repeated. For budgeting purposes, the Contractor may assume it is an annual mailing beginning in 2010.

358) Q: What is the estimated implementation date of the CHPlus premium assistance program?

Answer: That has not been determined. The Contractor should assume it will not be implemented before 2011.

359) Q: Could the State further define the roles of the Contractor versus the Department in disseminating public education materials about the Premium Assistance Program.

Answer: The Contractor can expect to disseminate public education materials in response to inquiries about the program and in the annual mailing. The Department will also disseminate public education materials in response to inquiries and disseminate the materials to local districts and facilitated enroller organizations.

360) Q: In what other languages (in addition to English and Spanish) will materials need to be produced for the Premium Assistance Program?

Answer: To be determined.

361) Q: Is the Contractor responsible for printing and postage?

Answer: Please see the RFP and this document for Contractor's responsibilities for printing and postage.

362) Q: What is the monthly volume of open enrollment mailings the Contractor will produce and mail for each year of the contract?

Answer: The open enrollment mailings will be done annually in the fall and will be to the current FHP enrollees. Currently that would be approximately 479,000 individuals in 350,000 cases.

363) Q: What is the estimated volume of brochures, fact sheets, and flyers?

Answer: 500,000 annually.

364) Q: Please provide examples of all currently used brochures, fact sheets and flyers used in promoting the PAP as mentioned in Section 2.b.i.

Answer: See Employer Fact Sheet Attachment 3, Recipient Brochure Attachment 4, DOH 4450 Employer Sponsored Health Insurance request for information Attachment 5, manual Notice of Decision (English and Spanish versions) Attachments 6 and 7.

See also **08ADM-01** and **General Information System (GIS) Message 08MA034,** on the Department website, under Medicaid/Reference Guides/Library of Official Documents.

365) Q: Send a mailing to FHP enrollees annually prior to the fall employer health insurance "open enrollment' periods. Not all employers maintain their benefit year to coincide with the calendar year when their fiscal year differs. How does the department maintain tracking these periods and how will this information be provided the Contractor?

Answer: The Contractor is required to send a mailing to FHP enrollees once annually in the fall.

366) Q: Please provide volumes for outbound public education documents?
-Who creates and distributes this material today?
-What is the cost per "piece" of each of these items?
-What are the production requirements for the material (i.e.: glossy finish for brochures, etc.)?
Please provide inventory and samples of outbound education documents?

Answer: The State develops and prints most of the public education documents used. In very infrequent circumstances, the Contractor may be asked to design and produce a two page flyer. See Attachments 9 and 10.

367) Q: What is the estimated volume and length of calls for Premium Assistance?

Answer: Unknown

368) Q: What is the estimated volume of premium assistance members that change employers each month for each year of the contract?

Answer: Unknown

369) Q: Is the Contractor precluded from contacting employers directly to assist members in obtaining employer plan information due to HIPAA requirements?

Answer: Subject to the usual confidentiality requirements of the Medicaid/FHPlus programs, the Contractor can communicate with employers in order to obtain the information needed to determine if the health insurance policy is both acceptable and cost-effective. Pursuant to Social Services Law 143, all employers of any kind doing business within the state of New York are required to furnish information requested by the Medicaid program, including information regarding employees' health insurance coverage.

370) Q: What are the premium payment amounts?

Answer: See the cost effectiveness calculator (**08ADM-01, Attachment D,** and **GIS 08MS034).** Premium amounts will vary depending upon the number of people covered and the frequency of the payment.

371) Q: Please provide the methodology for calculating Premium Assistance Program cost effectiveness.
Q: Please provide the following information: What is the methodology for calculating cost effectiveness?

Answer: See **08ADM-01, Attachment D,** and **GIS 08MS034** on the Department website, under Medicaid/Reference Guides/Library of Official Documents.

- How often are checks processed from the eMedNY system?

Answer: Checks are produced weekly.

372) Q: What is the estimated time to perform the cost effectiveness calculation?

Answer: The Excel spreadsheet will perform the calculation. Entering the data into the spreadsheet should only take a few minutes.

373) Q: What if the customer doesn't agree with the premium calculation? Is there an appeal process?

Answer: The fair hearing process is available.

374) Q: What is the Contractor's role in an appeals or Fair Hearing process?

Answer: The Contractor will be responsible for maintaining complete records and assembling the documents. The State will provide oversight and represent the Enrollment Center at Fair Hearings.

375) Q: Will an outside Contractor develop the Health Insurance Premium Payment Calculator? If yes, which firm?

Answer: No.

376) Q: How does the Department handle the processing and reimbursement of premiums, coinsurance etc. today? Is there a system to handle this beyond the check issuance out of eMedNY? Are claims for reimbursement of premiums, co-pays etc handled through MMIS? Would this process continue?

Answer: Districts currently use the WMS Benefit Issue Control System to make reimbursements.

377) Q: What is the status of the renewal form for members with access to employer based insurance? Please include a copy of the form.

Answer: There is no special renewal form for Medicaid and FHPlus enrollees receiving premium assistance. They receive a regular mail renewal form.

378) Q: Is the Department willing to provide the Contractor with a data extract from the state TPL database (TPHI)?

Answer: The Contractor will have access to information the Department determines it needs to carry out its responsibilities.

379) Q: How many staff members are currently dedicated to receive and process Premium Assistance Program documentation/receipts?
Q: What is the volume of documentation/receipts related to the Premium Assistance Program that the state currently receives per month?

Answer: Staffing varies by LDSS. The volume of documentation is unknown as such material currently goes to the LDSS.

380) Q: What is the process of handling cases of documentation submitted after eligibility determination has been processed?

Answer: See the **Medicaid Reference Guide** on the Department website, page 370, "Reapplication."

381) Q: What is the timeframe for processing Premium Assistance Program documentation?

Answer: The timeframes are the Medicaid timeframes, 30 days for children and 45 days for adults.

382) Q: Will the Enrollment Center be the only entity to process Premium Assistance Program renewals/relevant documentation/receipts?

Answer: No, not initially. The EC will process FHP PAP renewals for certain local districts before it takes on the responsibility statewide. However, if it is handling these cases for a district, the district will no longer have this role.

383) Q: Please describe the claims payment process in detail.
-How are payments received and processed?
-Please describe how the Check Issuance system works.

Q: Please provide a description of the functionality of the check issuance subsystem.

Answer:

- Enter the payee name, address etc into eMedNY
- eMedNY assigns a payee ID number
- Create payment by entering the payment type, amount and frequency. Payments may one time payments or regular recurring payments.
- Payment is then authorize by someone other than the individual creating the payment (security roles)
- Check will be cut by the fiscal agent and go out on the next Wednesday with their normal payment disbursements.

384) Q: What kind of file format is needed to interface with eMedNY? For reimbursements is a claims format used?

Answer: This should not be a Contractor issue. The Contractor would have access to the necessary State systems and would use those. The Contractor would not be using its own system.

385) Q: How many families are participating in the Premium Assistance Program today? What is the average number of receipts or other verification of health insurance premiums, coinsurance, deductibles, and copayments for Medicaid and FHP Premium Assistance recipients?
Q: The Premium Assistance Program for Medicaid, FHP, and CHP is expected to have annual volumes of 5,000 to 25,000. Currently, the Medicaid and FHP programs are operational, but the CHP program has not been implemented. What are current volumes for the Medicaid and FHP Programs?

Answer: A total of $154,000 has been paid in premium payments for the 600+ upstate FHP Premium Assistance Program enrollees. Enrollees in the regular Medicaid program may also qualify for Medicaid payment of an employer plan premium. We have no current means of measuring the number of Medicaid eligibles receiving premium assistance. We estimate the number to be less than 5,000. The new HIPP program when complete will provide us with the ability to do statistical analysis.

386) Q: Is the Contractor expected to provide the system for tracking employer coverage in New York or will it be provided by the State?
Q: Is there an existing database of participating employers?
Q: Reference is made to the Contractor amassing a database of employer coverage. What is envisioned to maintain this database and is there any similar database maintained today which will be expanded?
Q: "…the Contractor will begin to amass a database of employer insurance coverage in New York." Does DOH have specifications for this database? What are the requirements for the database?

Answer: Within the eMedNY system there is an employer database. It is functional, but currently not used by local districts. Its purpose is to collect employer information, including the types and cost of health insurance offered by those employers. The Contractor is responsible for developing a data base on employer coverage and may use the information in this database to develop an up-to-date, more useful employer database.

387) Q: This section states that the Contractor is responsible for verification of the validity of paid claims documentation. What is the Department's expectation for the Contractor in terms of this requirement?

Answer: Receipts submitted for reimbursement must be genuine and valid prior to the Contractor authorizing reimbursement. For example, the receipt must be produced by a provider and must be for service within the eligibility period.

388) Q: This paragraph states "Once an applicant is determined eligible to participate in the premium assistance program, the Contractor will (re)authorize and enter payment lines as necessary in the check issuance screens in eMedNY. Payment lines may be entered for the payment of premiums, coinsurance, co-payments and deductibles to the health plan carrier, employer or to the policyholder, as appropriate."

- Would the Department allow the vendor to use its own proprietary interface for making such determinations and automatically upload payment lines in a batch file upload to eMedNY on an agreed upon schedule?

Answer: No. The Contractor will have direct access to the check issuance system in eMedNY.

389) Q: Will the Contractor be required to outreach to members when they miss submitting documentation for premium paid, coinsurance, deductibles and co-payments?

Answer: At minimum, enrollees must provide proof of premium amount at the time of application and renewal, or when a change has been reported. Failure to provide proof may result in the discontinuation of premium reimbursement and/or program eligibility.

390) Q: Will the Contractor be required to outreach to disenrolled members when they miss submitting documentation for premium paid, coinsurance, deductibles and co-payments after a certain period of time?

Answer: No.

391) Q: Can premium payments skip months?

Answer: No.

392) Q: If premium payments can skip months, how many can the employer miss before the employee is disenrolled from the program?

Answer: N/A

393) Q: Can premium payment be retroactive?

Answer: Yes.

394) Q: If premium payments can be retroactive, how many months can be requested?

Answer: A FHP PAP enrollee may be reimbursed for cost sharing back to the date of initial eligibility. For example: A person applies for FHP PAP in January. In February she is determined

eligible for FHP PAP, effective 1/1/09. Cost sharing reimbursements may be made for expenses paid by the recipient back to January 1, 2009.

395) Q: Currently, how often are the premiums paid being verified?

Answer: At minimum, enrollees must provide proof of premium amount at the time of application and renewal, or when a change has been reported. Failure to provide proof may result in the discontinuation of premium reimbursement and/or program eligibility.

396) Q: Verification of premium assistance claims – Other than duplicate checking is there any other rule to ensure program integrity?

Answer: Yes. For example: 1. There are security roles in place within eMedNY that limit a person's ability to authorize payments above a certain dollar amount. 2. The person who creates a payment cannot be the same person that authorizes the payment. 3. Each time a payment is authorized, eMedNY checks recipient eligibility.

397) Q: Enrollment Center must have 98% accuracy of cost-effective analysis and collect premiums from employers - what are DOH's collection policies (e.g., delinquency notices, formal actions, use of third party collection agencies, suspension of service, etc.)?

Answer: Premiums are not collected from employers for FHP-PAP. They may be collected for the FHP Buy-In.

398) Q: How often are enrollees in the program expected to renew their eligibility?

Answer: Annually.

399) Q: On a monthly basis, what volume of Premium Assistance Program members fail to provide the information needed and are disenrolled from the program?

Answer: Unknown

400) Q: Will eligibility for Premium Assistance and FHP Buy-in Program be determined annually or more frequently?

Answer: Annually.

401) Q: What is the expected frequency and format of Premium Assistance Program Reporting?
Q: Clarification is needed for "any other reports required": type, volume, and timeframes.
Q: Please confirm the frequency at which the Premium Assistance Program reports are due, i.e., monthly, quarterly, etc.

Answer: CMS requires the following reports:

Report period	**Information to OMCPE Bureau of Program Planning**	**Due to CMS**
Jan1-March31	April 27	May 30
April-June 30	July 31	Aug 30
July 1-Sept 30	October 27	Nov 30
Oct1-Dec 31	Jan 25	Feb 28

On a quarterly basis we would report:

Enrollment in ESHI through FHPlus PAP	**Total Current Enrollment**	**New Enrollment in Current Quarter**
FHPlus Adults with children		
FHPlus Adults without children		

This list is not inclusive and will be more fully developed with the Contractor.

402) Q: What is the process for processing a case in which the employer does not return the required documentation?

Answer: See **08ADM-01** on the Department website, under Medicaid/Reference Guides/Library of Official Documents.

403) Q: What is the Department's formula or method for determining 98% accuracy rate for cost effective analysis determinations?
What is the benchmark for determining the accuracy of cost-effectiveness analyses?

Answer: The Department will calculate the 98% accuracy rate by dividing the number of monthly cost effective analysis calculations that were correct by the total monthly cost effective calculations.

Family Health Plus Buy-In Program

404) Q: Please provide the procedure manuals for eligibility for the FHP Buy-in.
Q: Are there policies and procedures related to both the employer buy-in program that are available?

Answer: Information on the FHP Buy-in will be provided at a later date.

405) Q: How many individuals are currently enrolled in the FHP Buy-In program?
Q: Please clarify the profile and estimated number of individuals without employer affiliation eligible to directly enroll in the FHP Buy-In program via the Enrollment Center? Section 4 does not mention individuals, but the cost section (Cost Worksheet Section d, pg 54) does.
Q: What is the number of employers expected to participate in the FHP Buy-In program?

Answer: Only individuals who are qualifying employees of an employer participating in the FHP Buy-In program can enroll. No individuals without such employer affiliation can enroll in FHP Buy-In.

One employer is currently participating in the FHP Buy-In. At this time, there is no estimate of the number of employers or employees who may ultimately participate. Currently there are several legislative proposals under consideration that could have an impact on employer participation rates.

406) Q: Please provide an estimated ratio of the estimated number of employers/average number of individual/families participating per employer.

Answer: Legislation does not limit the number or size of employers participating in the FHP Buy-In. An estimated ratio of employees/average number of employees/enrollees is thus not readily available. The current participating employer has approximately 49,000 eligible employees and dependents.

407) Q: Is the employer Buy-In program active today or will the Contractor be responsible for initial implementation?

Answer: There is currently one employer participating in the program. There is a possibility that the program will be expanded to additional employers in the future.

408) Q: What is the expected range of employer profiles the State expects to participate in this program? Has there been publicity for the program already or will the Contractor be responsible for the initial education and outreach associated with the program?

Answer: To date, there has been little publicity for this program. It is anticipated that the Contractor will be responsible for educational materials to assist new employers in implementing the program.

409) Q: Are their procedures and/or regulations defined for this program?

Answer: Regulations have not been promulgated and procedures are currently in place for the single employer currently participating at this time. However, program modifications will be needed to further implement this program.

410) Q: Renewing Eligibility in the Buy-In plan – Enrollees into the FHP renew via the Enrollment Center (regardless of whether they are eligible via the buy-in program or not). What employers are eligible? All employers in the state? Does employer eligibility in the buy-in program have to be renewed on a regular basis?
Q: What are the eligibility requirements for employers to participate in the buy-in program?

Answer: At this time, there are no specific eligibility requirements. We are not anticipating that employer eligibility will be renewed on a regular basis.

411) Q: Are the starting volumes described, 20,000 to 50,000, the volume of employers or enrollees?
Q: How is the Renewing Eligibility volume of 20,000 to 50,000 derived?

Answer: This volume is referring to the number of enrollees who could possibly be eligible for government programs.

412) Q: What is the expected volume of employers participating and the volume of employees?
Q: Please provide the volume of employers participating in the FHP Employer Buy-in Program.

Answer: Currently there is one employer participating in the program. It is unknown what the volume of possible new employers to the program will be. We do not anticipate this program being implemented in the first year. Bidders should use the volume projects provided in the RFP to develop their proposals.

413) Q: What is the estimated monthly volume of FHP Buy-In program renewals that will be processed by the Enrollment Center (members who can self-attest to their income and residence)?

Answer: That number is uncertain.

414) Q: Will facilitated enrollers be engaged by the Department to conduct outreach for the FHPlus Buy-in program in the same way they are currently engaged for Medicaid, CHPlus and FHPlus?

Answer: No

415) Q: Please provide DOH's collection policies (e.g., actions based on days delinquency notices, formal actions, use of third party collection agencies, suspension of service, etc.)?

Answer: At this time, there are no policies /procedures in place in these areas.

416) Q: Can premiums, coinsurance, deductibles or co-payment reimbursement requests skip months?

Answer: No.

417) Q: If premiums, coinsurance, deductibles or co-payment reimbursement requests can skip months, how many can the enrollee miss before they are disenrolled from the program?

Answer: Employees with premium contributions would be subject to customary employer/plan commercial arrangements regarding the length of time from missed payments to disenrollment.

418) Q: How long does the enrollee have to provide documentation for reimbursement for premiums, coinsurance, deductibles or co-payments?

Answer: In order to be in the program, the employee must be eligible for a government program such as Medicaid, Family Health Plus or CHPlus. If paying a premium is an eligibility factor to be eligible in a given month, the enrollee must provide the documentation within that month of coverage.

419) Q: Is there a retroactive enrollment/retroactive reimbursement process in place?

Answer: There is no retroactive enrollment/reimbursement process for the FHP Buy-In Program.

420) Q: How does an employer offer Family Health Plus Program to the employees since this is a requirement for the FHP Buy-In Program?

Answer: Instructions will be provided for how employers can participate in the FHP Buy-In Program.

421) Q: What is meant by the first paragraph – "..authorized to issue an RFP…" Is there eventually going to be another RFP or is this scope in the Enrollment Center RFP?

Answer: This refers to the statute authorizing the program and the Department's responsibility to implement it. There will not be another RFP. The Department believes that this program should be managed by the Enrollment Center, as we move toward a more coordinated eligibility system.

422) Q: What are the responsibilities for the Contractor acting as the fiscal intermediary?

Answer: Please see the RFP.

423) Q: What is the process for resolving a case where an employer does not pay in full?

Answer: All employers are expected to pay. If payment is not made, the employee would be converted to a regular FHP plan. If the employee is not eligible for a state program, the employer and insurance company would need to resolve the non-payment issue in the customary manner in place between the employer and insurer.

424) Q: Please define/provide a profile of the "non-subsidized employees" for whom the state reserves the right to include and the role of the Enrollment Center, if any, in serving this population.
Q: Once an employer ceases to remit the employer share of the buy-in premium it states that "Subsidy eligible employees would be transferred/enrolled in the Family Health Plus program directly." What is the definition of a "subsidy eligible" employee? Do all employees continue to be eligible via a COBRA extension?

Q: Is the transfer of enrollees onto FHP when an employer ceases to participate like a COBRA transition whereby the enrollee is required to pay the full amount of the premium?

Answer: A non-subsidized employee is one whose family income exceeds the eligibility threshold for FHPlus, whose coverage would be paid for by the employer and the employee, without a state subsidy. A "subsidy eligible" employee would be one whose family income is below the threshold for FHPlus.

If an employee is eligible for a government program, they would convert to the regular program (Medicaid, Child Health Plus or Family Health Plus). If not fully subsidized, they would be eligible for COBRA continuation coverage following the rules for that program.

425) Q: Please define education to health plans and employers and expected frequency and preferred medium for education – initially and ongoing.

Answer: Flyers and brochures to be developed by the State, which will be mailed by the EC upon request from employer or enrollees.

426) Q: Is the Contractor required to handle claims associated with this program?
Q: Will the Contractor be responsible for billing premiums to the employer and employee participants in the program or will that be handled by the Department?

Answer: The Contractor will not handle claims, defined as reimbursement for a service. They will handle claims, defined as the employer and employee premium contributions. They will be responsible for billing. Please see the RFP.

427) Q: Will the Enrollment Center be sending invoices to employers and/or individuals for the premium amounts owed, and if yes, how often are these invoices sent out?
Q: Please provide current volumes, org charts and system design documents. Please also include any process documentation to support FHP.
-How do employers process payments today?
-What banks are currently used to process employer payments?
Q: Does the Department anticipate that the Contractor will develop a separate system for the FHPlus Buy-In program for enrollment and transaction processing or will the existing state systems be adapted to accommodate this program?

Answer: Currently, the payments for non-subsidized employees are between the employer and the health plan. The State will pay some or all of the premium for employees otherwise eligible to directly enroll in a government program, and the Contractor would be responsible for collecting the employer contribution, if any, for these enrollees. The Contractor would be expected to design the process and system, with consultation with the State, as additional employers elect to participate in the program.

428) Q: What systems will the Contractor need to integrate with?
Q: Please define the known state and employer systems for integration with vendor systems and vendor's anticipated access to such systems

Answer: The Department will provide an interface to the relevant systems once the program is developed.

429) Q: Please clarify the disenrollment rules for employers/individuals who do not pay their premiums and protocols for handling of instances in which the employee pays contribution and the employer does not; or in instances where the employer only pays partial share of premiums owed.

Answer: Customary rules and protocols used between a plan and employer would apply for cases of non-payment of employer or employee premium contributions. There is no state-defined process in place.

430) Q: Is it reasonable to expect that participating employers will be able to exchange all necessary data electronically?

Answer: The Department uses DOH 4450 Form, (Attachment 5) for employer data requests. The vendor could reasonably expect this to be transitted electronically

431) Q: How often will premiums be collected from employers/individuals?
.
Answer: Premiums will be collected on a monthly basis.

432) Q: Are Public Education materials to be designed for dissemination to employers or potential enrollees?
Q: Per the RFP, the Contractor will assist the State in developing and disseminating public education materials about the FHP Buy-In Program. What will be the Contractor's responsibility for disseminating the material?
Q: What assumption should the Contractor make related to the method of dissemination of the FHP Buy-In Program materials.
Q: The Contractor will be responsible for developing brochures, fact sheets, and flyers for consumers promoting the FHP Buy In program. Can the Department provide samples of current such materials that vendors can use to scope this responsibility? Can it share with bidders the materials that are currently used in the Medicaid managed care program? Will any materials be produced by the Department?
Q: What is meant by 'disseminating public education…' to what extent would the Contractor be required to disseminate such materials, and is there a defined volume/scope to this requirement?
Q: In what timeframe must materials be printed and disseminated for the FHP Buy-In Program?
Q: Please provide estimated volumes for brochures, fact sheets and flyers.
Q: Is Contractor responsible for printing and postage?

Answer: Currently the Department is responsible for creating marketing materials. The Contractor will be responsible for requesting theses materials from the Department Distribution Center. Flyers and brochures will fit in a standard envelope and may be mailed with first-class postage. Any additional marketing materials that are needed will be discussed with the Department prior to creation to determine an agreed upon price and due date. The Department estimates the volume to be 20,000 – 25,000.

433) Q: Are employer payments linked to individual employees or groups of employees?

Answer: Payments are linked to individuals.

434) Q: Per the pricing schedules, the Contractor will price the development and updating of materials only. Should the Contractor include the cost of disseminating FHP Buy-In education materials in the unit cost of FHP Buy-In application processing?
Q: If the Department does not direct the Contractor to include the cost of disseminating FHP Buy-In education materials in the unit cost of FHP Buy-In application processing, how would the Contractor be reimbursed for the cost?

Answer: Yes the cost of mailing FHP Buy-In materials should be included in the bid price for handling applications and renewals for FHP Buy-In.

435) Q: How, and from whom, will the Contractor, acting as the Health Plan Coordinator for FHPlus Buy-in, receive information about which employees working for a particular employer are eligible for premium subsidies and the amount of those subsidies?

Answer: The employer will screen employees for possible eligibility for government programs. This list will be matched with current state program eligibility information to ascertain which employees are already in receipt of assistance, and which employees will need to apply for assistance. Coordination between the State, Contractor, employer and plan will be needed in order to determine appropriate payment needed from each employer.

436) Q: Please provide estimated volume and length of calls.

Answer: Unknown

437) Q: How often will the Contractor have to verify or confirm the subsidy status of employees working for each participating employer?

Answer: This will need to be done monthly.

438) Q: How does a FHP member's eligibility timeline impact with employer's Open Enrollment? For example, an FHP member's renewal period may be 3/09 and the employer's Open Enrollment period may be 12/09.
Q: Are renewals of eligibility tied to the employer date of enrollment/participation, the individual anniversary date of enrollment, or both?
Q: Are enrollees enrolled in the FHP Buy-In through their employer enrolled for one full year of continued eligibility (assuming the employer remains enrolled) or is eligibility for enrollment determined at intervals shorter than annually?

Answer: For individuals enrolled in government programs, their renewal period does not need to coincide with an open enrollment period. If at the time of the renewal, the employee is going to be no longer eligible for a government program, the employee would convert to unsubsidized enrollment.

For non-subsidized members, the employer may apply criteria to determine which employees are eligible for health insurance on an ongoing basis, such as number of hours worked.

439) Q: What is the expected frequency and format of Buy In Program Reporting?

Answer: Reporting will be quarterly, the bidder may propose the format.

440) Q: Once an employer is enrolled in the program, is it assumed that all employees of the respective employer are eligible to participate?

Answer: Yes, however, in order to be subsidized, the employee would need to be determined eligible for a government program.

441) Q: What is the nature of assistance that would be needed for employees if there is a change in employer coverage? Is this only when an employer chooses to no longer participate in the buy-in program or are there other circumstances?

Answer: The employer or health plan would be responsible for notifying employees/members of changes in benefits, withdrawal from the program, etc. and the Contractor may have a role in answering questions from enrollees via the call center.

442) Q: Please confirm the frequency at which the FHP Buy-In Program reports are due, i.e., monthly, quarterly, etc.
Q: How often must the Contractor provide reports?

Answer: As with the other projects in the RFP, the FHP Buy-In will have quarterly reports, due COB on the last day of the month following the end of the quarter being reported on. If that day falls on a weekend or State holiday, the report will be due the next business day.

443) Q: Since some of the reports include averages over time, does DOH expect historical data to be reflected in the reports? What database has been/will be used to track?

Answer: It is anticipated the vendor will use their own database to provide reports.

444) Q: Please explain who will be responsible for processing FHP Buy-in applications for the FHP Buy-in subsidized population prior to the phase-in of this approach (Web-based renewal) through the Enrollment Center.

Answer: It is anticipated that the process will remain as currently in place. The LDSS is responsible for the eligibility determination for Medicaid and Family Health Plus.

Web-based Renewal

445) Q: Who maintains this web application?
Q: Please describe the Contractor's responsibilities, if any, to develop and/or maintain the technology for the web-based renewal system.

Answer: This is not yet determined.

446) Q: Who pays for the support for this application?

Answer: This is not yet determined.

447) Q: What are the future requirements for Web-based renewal?

Answer: These are not yet determined

448) Q: Will the Contractor have any data-entry responsibilities regarding information entered by an enrollee through the renewal website?

Answer: The Contractor's role would be follow-up processing/validation/verification of the renewal application that was submitted.

449) Q: The RFP states that enrollees will authenticate themselves to the Web-based system. Please describe the Web-based system. Has development on this system been initiated? If so is there any requirements documentation available to vendors? Will it be done internally or contracted to an outside vendor?

Answer: The Web-based system is not yet developed; therefore, we are unable to answer these questions at this time.

450) Q: Under telephone and mail-based renewal, the Contractor is responsible for sending mailings that request outstanding information or documentation. However, this subsection says "the web-based system will create" the mailing. Please confirm the Contractor's responsibilities in this regard.

Answer: Most of the notices specific to the renewal process will be generated by the Client Notices System automatically. The Contractor will be responsible for following up on outstanding information needed for a renewal. This follow-up responsibility would be the same for telephone, mail, or web-based renewal.

451) Q: How is this the same or different than the telephone-based renewal process as it relates to health plan changes?

Answer: While the specifics of the web-based renewal system have not yet be determined, it is the State's intent that the process and responsibility of the Enrollment Center regarding health plan selection be similar for all enrollees that are renewing.

452) Q: "Center must process web-based renewals in timely fashion." Could the Department define "timely fashion"

Answer: To be determined.

453) Q: Please clarify the Enrollment Center's responsibility for a 97% accuracy rate for data that is entered by an enrollee through a website?
Q: How can an accuracy standard be applied to data entered by the enrollee via the web?

Answer: The accuracy rate refers to data entry and processing by the Enrollment Center of the data provided by the enrollee.

454) Q: Regarding the statement that the Enrollment Center staff "enters the information in WMS, MBL, eMedNY, EEDSS, and KIDS." Please indicate if the Department envisions granting the Enrollment Center staff the same level of system privileges that are currently available to state and LDSS employees?

Answer: Privileges will be defined as appropriate to the training and responsibilities of the EC worker.

455) Q: Is the state going to be responsible for the development of the web-renewal tool or is the Contractor?

Answer: The state will.

456) Q: At what point in the project will the electronic renewal tool be complete? Will there be an opportunity for input into the design based on the Contractor's experience with web-based enrollment tools?

Answer: The renewal tool will be completed prior to implementation. The Contractor will have the opportunity for input into the design of the web-based enrollment tool.

457) Q: Which platforms must the web-based renewal system support?

Answer: To be determined.

458) Q: Will web-based renewals come to the Enrollment Center in real-time?

Answer: To be determined.

459) Q: When a member uses the web-based renewal, will the system make a final determination or does the Contractor still need to review and process the data?

Answer: The Contractor will need to process and review the data using the system recommended determination.

460) Q: Is the web screening applicable to renewals only or also for new applicants?

Answer: The goal is for new applications and renewals. The implementation steps are to be determined.

461) Q: Will the Contractor be responsible for implementing/designing the telephone/web renewal function in addition to providing support for this function or provide support only?

Q: The RFP states that "the Department shall develop a web-based application for renewal that will be available statewide". Is it the intention that the Contractor will be developing the web-based application for the Department? Will that application be used beyond the needs of the Enrollment Center mission? What is the timeline for implementation of this Web-Based Renewal System? What technology and integration is required with this system?

Answer: The Department would develop the web-based application. This is in the early planning stages at this point. The timeline for the web-based system is not yet determined.

462) Q: The RFP seems to indicate that the question set would preclude consumers from switching health plans on their own. Assuming they are not locked in, would consumers be allowed to change plans on their own, without contacting the Enrollment Broker or LDSS, if they wish to do so?

Answer: To be determined.

463) Q: How will the Contractor receive web-based renewals and in what format?

Answer: To be designed.

464) Q: Does the Enrollment Center have help desk responsibilities for the renewal website, such as re-setting passwords or providing technical assistance regarding the use of the site?

Answer: No.

465) Q: The section notes that "Enrollees will authenticate themselves to the web-based system using their Client Identification Number (Medicaid/FHP) or Enrollee Identification Number and health plan (CHPlus) and other identifying information."

Based upon V. C. 6. (Information Security Breach and Notification Act) would the Department recommend not using Social Security Number (or other information within the security breach section) as identifying information? Does the Department have reservations regarding other identifying information, such as Date of Birth or current address?

Answer: No

466) Q: How will enrollees be notified of their time to renew and availability of the web renewal option?
Answer: When web-based renewal is available, renewal notices will be revised to include web-based renewal as an option.

467) Q: Has the State agreed to system interfaces or data exchanges, with WMS and KIDS for the web renewal process, to allow for real time validations that a member has not already renewed?

Answer: Yes

468) Q: Please provide or direct us to the rules for enrollment "lock-in" with a health plan.

Answer: All Medicaid managed care enrollees residing in locals social services districts where enrollment in the Medicaid managed care program is mandatory and all FHPlus enrollees are

subject to a twelve (12) month lock-in period following the effective date of enrollment, with an initial 90 day grace period where they can change health plans without cause.

An enrollee subject to lock-in may disenroll from the Contractor's Medicaid managed care of FHPlus product during the lock-in period for good cause. The rules defining good cause are found in Appendix H of the Medicaid Managed Care/FHPlus model contract which can be found at the following link: http://www.health.state.ny.us/health_care/managed_care/docs/medicaid_managed_care_and_family_health_plus_model_contract.pdf

469) Q: Does the Department want e-mail or standard mail reminders?

Answer: Standard mail – which must go to the address of record. This is tied to verification of residence.

470) Q: How is this different or the same as the reminder notice referenced in V.C.5.c.i?

Answer: It is the same requirement – a reminder to the client to complete the steps necessary for renewal.

471) Q: When an enrollee requests a change in plan the Contractor is required to coordinate this change with the enrollment broker, LDSS, or health plan in the county. Is coordination with all three entities required in every situation or is it just one of the entities? How is it determined which one the Contractor needs to coordinate with?

Answer: The EC will have to coordinate with the entity involved in a county for plan selection. For Medicaid and Family Health Plus, it will be either the Enrollment Broker or LDSS. For CHPlus, it will be with a health plan. The Department will provide this information to the Enrollment Center.

472) Q: DOH has indicated that it will create the web-based renewal application (p32) and that the Enrollment Center is responsible for its ongoing maintenance. Please provide more information regarding the underlying technology (hardware, software, interfaces) of the application. Where will the application be hosted (DOH, Contractor, other)?

Answer: To be determined.

473) Q: If the Department develops and hosts the web-based renewal system, what specifically are the Contractor's responsibilities regarding its "proper maintenance."

Answer: To be determined.

474) Q: Would the Department expect that the Contractor reporting be carried out through Mobius Reports or through Contractor-supplied reporting systems?

Answer: This data would reside in the Contractor's renewal tracking system.

475) Q: The RFP mentions a future web-based renewal system. Will the Contractor be responsible for creation of this system? If so how does this fit into the pricing schedule in the proposal?

Q: The enrollment center shall enter all the information on the application directly into an electronic application through an interface designed for this purpose. Is the Contractor responsible for building this electronic application? Does the application interface into WMS, KIDs, RFI, MABEL, etc.? Is the Contractor responsible for building this interface?

Answer: The electronic application will be built by DOH and will interface directly with the system of record (WMS, RFI, MABEL, etc.)

476) Q: What is the expected percentage of enrollees who are eligible for subsidized membership?

Answer: Currently for the one employer in the FHP Buy-in program, there are approximately 9,000 enrollees (employees and dependents) eligible for the government health insurance program and 40,000 enrollees who are not eligible for those programs. However, it is unknown whether this ratio would apply for all types of employers.

477) Q: Who are "other application assisters" for the FHP Buy-In Program?

Answer: Facilitated Enrollers are an example of "other application assistors.

478) Q: Will the applications come from individuals or Facilitated Enrollers or both?

Answer: Both

Marketing and Outreach Materials

479) Q: Can we obtain samples of the current program brochures, fliers, applications, notices, and other materials that are developed and produced by the Department?
Q: Will the State provide samples of all marketing and outreach materials developed and produced (program brochures, fliers, applications, and notices) that will be available for the Enrollment Center?
Q: Will the Department provide examples of typical volumes of needed outreach materials?

Answer: The Access New York and Growing up Healthy applications can be found by accessing the following link: http://www.health.ny.gov/health_care/child_health_plus/application.htm. Please see Attachments 8 - 13. Volumes are referenced in question 248.

480) Q: The Contractor shall assist the State in developing and disseminating public education materials including, brochures, fact sheets, flyers and other materials.
A. Is there a site where the existing materials can be viewed or is it possible to obtain samples?
B. Do you anticipate expanding these materials?
C. How do you currently produce, store and manage your inventory of these materials?
D. What is your approval and review process for these materials?
E. How do you typically distribute brochures, fact sheets, flyers and other materials?
F. What components are to be included in the per page price?

Answer: The Contractor will provide a very limited role in supplementing the materials developed by the Department. Aside from the materials described for Premium Assistance and the FHP Buy-In Program, which are not included in this section, the Contractor can expect to only be called upon to produce limited materials for a specific event or marketing opportunity or in cases where both the Contractor and the Department identify an opportunity for new material. The Contractor will principally design the new material and will not be responsible for production and printing. There may be instances in which the window of opportunity to use a specific type of material does not permit the Department's usual process and the Contractor may be asked to design, produce and print the item (e.g., flyer). All component cost should be included in the per page proposal price.

Materials are stored in the Department's Distribution Center and requests for materials are made to the Distribution Center. Inventory is maintained by the Distribution Center and the Department. The Contractor will obtain nearly all the materials used in this contract from the Distribution Center.

New material must be approved by the Department, both the program and the Public Affairs Group. The approval process is not more than a few weeks.

The Contractor should assume that the page has 3-4 colors, includes graphics, and is printed on glossy paper.

481) Q: What is the expected volume/quantity of outreach, Premium Assistance Program, and Family Health Plus materials?

Answer: For outreach, the Contractor will use materials readily available from the Department's Distribution Center with a few exceptions described above. The Contractor will design both the

Premium Assistance and Family Health Plus Buy-in brochures once those parts of the Enrollment Center are implemented. These are special programs within larger programs and the volume of materials will not be as great as those prepared for the overall programs. We expect enrollment in the Premium Assistance programs to be 1-2% of all Family Health Plus Enrollment or 4,000 to 6,000 people. There are no estimates of volume for the Family Health Plus Buy-in program.

482) Q: "Other languages may be required for targeted enrollment events." Please identify the other languages that may be required.

Answer: The languages specified in this section represent the main languages spoken among the enrollees. The requirement to develop material in another language will only occur in the circumstance in which the Department conducts a targeted enrollment event to a population that speaks a different language. This would be a rare occurrence and would be negotiated between the Contractor and the Department.

483) Q: "Translations must be done in a timely and accurate manner." What does the Department consider to be "timely" and "accurate?"

Answer: The translation of a flyer (1-2 pages), if required, should be completed in two weeks. Accurate means that the translation accurately reflects the English meaning.

484) Q: What is meant by media materials?

Answer: Flyers and brochures.

485) Q: "The Contractor shall not be paid for the production of education, outreach, enrollment, and/or media materials that are produced with material inaccuracies, including those resulting from typographical errors, or that do not incorporate all agreed upon changes, nor for the re-printing of materials that are found to be in error, except when such materials or information were provided by the Department or the LDSS." What does the Department consider to be "material inaccuracies" and "in error?"

Answer: A material inaccuracy provides erroneous information about the program, whether it be the eligibility criteria/levels or other information that would mislead the reader. "In error" means printing with typographical errors or inaccurate information that necessitates the re-printing of the material.

486) Q: Does the Department expect the Contractor to print and deliver new outreach materials and annual updates of applications or materials in addition to development of such materials?

Answer: Perhaps, but only on those items prepared by the Contractor in the first instance, if they continue to be used.

487) Q: What volume of materials is expected to be needed for enrollment events?

Answer: An enrollment event has several hundred fliers, brochures, and applications.

New Applications and Other Renewals

488) Q: Under the task of Processing New Applications and Other Renewals, is the grantee expected to help individuals apply for community-based or institutional long term care services?

Answer: No.

489) Q: Please provide current or expected daily, monthly, annual volume of applications for the past 12 months and projected levels.

Answer: We do not expect the Enrollment Center to handle new applications in year one. Bidders should use the volume bands in the RFP to develop their proposals**.**

490) Q: What is the estimated time to process eligibility for each program (a-g)?

Answer: An interview takes between 30-60 minutes. Any necessary reconciliation of documents and data takes additional time. The required timeframes for eligibility determinations are 30 days for pregnant women and children, and 45 days for adults.

491) Q: For each program (a-g), what percent of applicants' initial application must be pended until documentation or missing information is provided?

Answer: Nearly all people who come to local district to apply must have their application pended for additional information/documents. This is because they usually don't know what they need to provide until they talk with a worker.

Most applications started by Facilitated Enrollers are well-documented when they arrive at the local district, and do not need to be pended.

492) Q: If and when the Department implements this section, does it anticipate also allowing applications from individuals through the renewal website as described in Section V.C.5?

Answer: Yes.

493) Q: What are the criteria for determining the accuracy of potential eligibility determination?

Answer: The EC must ensure before the case is sent for State review and determination, that all documentation is collected and that there are no outstanding or incorrect responses which could result in an incorrect eligibility assessment by the EC.

494) Q: This section lists numerous programs where the Contractor may eventually perform services for new applications and renewals from these populations. Can the Department provide more information about the volume of likely participants in these programs and what the current application and application and renewal process is for each program?
Q: What is the expected timeline for New Application processing and Other Renewals? Please provide application volumes and sample applications for each of the groups identified in C.
Q: What is the expected additional volume expected from these new applications, and is there a plan to determine how/when they are phased in with success?

Answer: Program applications are posted on the Department website, through links in the information page(s) about the specific programs. Most programs use the Access NY Health Care application. The Medicaid Savings Program has a short application. The Medicaid Reference Guide provides program rules.

There are about 6,500 MBI-WPD participants currently. Other information on volume is not readily available.

495) Q: What are the technical differences for variant eligibility rules? Is the addition of new populations negotiable?

Answer: The differences in eligibility rules are established in federal and State statute and regulations. The Department will work with the Contractor regarding the timeframe for including new populations to the Enrollment Center's responsibilities.

496) Q: Do you receive any applications via fax?

Answer: Local districts do receive applications by fax, but require a hard copy of the signature page.

497) Q: How do you store applications and documents today? Do you digitize any of the paper?

Answer: Currently, the LDSS is responsible for retaining the documents for the cases it processes. The methods vary by district. Many districts image their documents.

498) Q: Is there a system that reflects that an application has been submitted but it is pending submittal of documentation or corrections?

Answer: No.

SYSTEMS

499) Q: Given the number of State provided systems the Enrollment Center vendor is required to use, will the Department provide demonstrations of each system to be used in performing contract operations prior to or in conjunction with the bidder's conference? This will assist interested bidders with estimating processing time for applications in addition to providing valuable insight needed for responses.
Q: Please provide a systems manual for each system to be used to perform contract operations:
Q: Who is responsible for technical support of the systems identified in this section.
Q: Is it expected that the same applications/systems will be used by the new vendor operating the call center (WMS, MABEL, RFI, CNS and eMedNY), or will other applications be necessary in the immediate future (year 1)?
Q: What access rights (read, write) will the Contractor have to each of the following systems?
WMS, MABEL, CNS, RFI, eMedNY, EEDSS, Centraport, KIDS
MRT, Mobius Reports
Q: When will the Contractor have access to documentation for systems named in the RFP?
Q: What are the requirements or constraints around interfacing the Enrollment Center and State databases?

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Q: When will the Contractor have access to documentation for systems named in the RFP?
Q: What are the requirements or constraints around interfacing the Enrollment Center and State databases?
Q: Please elaborate on the access rights that the Contractor will have to the information systems listed in this section.
Q: Will the Department provide a crosswalk between the systems listed on page 15

Answer: The State is developing an electronic tool that will be used by vendors to enter renewal information. That tool will be the interface with other Department systems. The vendor will be trained on the use of the tool. The Department is responsible for technical support of the systems identified in this section. The vendor will be interfacing directly with the Child Health Plus KIDS system (Knowledge, Information and Data system). During the start-up phase of this contract, the Department will provide a demonstration.

The Contractor will have full access to the renewal tool and read-only access to WMS. It will have full access to KIDS for the second year.

Extracts of data stored will be provided as necessary for the Contractor to build and maintain tracking systems. In addition, when the vendor assumes responsibility for the Premium Assistance Program, they will have access to and be trained on eMEDny.

500) Q: Are WMS, MRT and KIDS able to provide information in electronic file format? For example, can any of them produce a file of all cases with two weeks of eligibility left, or must they be accessed on a day by day case basis.

Answer: Electronic data exchanges may be developed as required.

501) Q: Is there an existing imaging system that is used by the various parties involved in the process? Please provide details on the imaging system if applicable.
Q: Is any document imaging currently used? If so, are these images accessible to the Enrollment Center?

Answer: Yes, but it varies by district. The Contractor will have access to the NYC imaging system and the OTDA system. A few small districts may not be included and the Contractor may need to work with those districts to get the images.

502) Q: If the State does not have a repository tool used to maintain images, does the State require that the Contractor supply such a system?

Answer: The Contractor is not expected to supply an imaging system.

503) Q: Is WMS capable of maintaining document images associated with the case file?

Answer: Documents related to cases in WMS are held in an image repository

504) Q: Is there a common identifier between the systems (e.g. CIN), and documentation available describing the architecture/relationships between the state systems involved?

Answer: Yes, there is a common identifier for the individuals and the cases to which they belong as well as personal demographics.

505) Q: The RFP stipulates that the Contractor will ensure proper maintenance of systems and will ensure that all interfaces, hardware, software and mission-critical equipment continue to function properly and efficiently. Please confirm that these statements refer only to those systems, hardware, etc that Contractor brings to the solution and not to State owned systems.

Answer: That is correct.

506) Q: Is information entered into the State provided systems updated in real-time or through a nightly batch process?

Answer: eMedNY updates are in real time. WMS updates eligibility records to the mainframe by batch overnight**.**

507) Q: Several areas of this section discuss the need to link imaged documentation with the correct case in WMS. What kind of system does the Department currently use to load scanned documents into WMS?

Answer: I/EDR

508) Q: Please describe the electronic file system. What application or system supports this? How is it accessed?

Answer: I/EDR are accessed on-line and will be made available to Enrollment Center staff.

509) Q: Is there any requirement to retain hard copy application or documentation once the hard copy document is scanned as long as they are destroyed in a HIPAA compliant manner.

Answer: Currently OTDA requires their subcontractor to keep hard copies of documents for 60 days past the date of the scan, if the county is using I/EDR services. Shredding of the hard copies in a HIPAA compliant manner is acceptable.

510) Q: Is eMedNY or WMS used as the system of record for recording the health plan and the lock-in period for Medicaid/FHP recipients?

Answer: eMedNY

511) Q: Does WMS generate 834 transactions?

Answer: WMS does not generate 834 transactions.

512) Q: In saying the "Contractor shall develop a tracking system for renewals including procedures and systems" does the Department mean?

1. The Contractor shall implement a systematic business process that tracks renewals?
2. The Contractor shall implement an information system that tracks renewals? In the latter case, what options are available to integrate with state systems such as WMS to provide end-to-end visibility?

Answer: The Contractor shall implement an information system that tracks renewals. It is anticipated that the Contractor will be provided with an interface of individuals who are being notified of renewal due and those that are in clock-down to use in their tracking systems.

513) Q: If the Contractor is required to maintain a separate tracking system for renewals, would the state consider receipt of a file to update its EEDSS or WMS system to avoid dual data entry?

Answer: It is anticipated that the renewal population would be loaded via an interface to the tracking system and would be updated in the tracking system by the renewal tool.

514) Q: To enable greater efficiencies, would the Department allow any interfaces between the IVR and the state systems to increase automation of calls (e.g., status of applications, etc.)

Answer: The system is designed such that a caller reaches a live person for a renewal interview. If based on experience a bidder chooses to propose the use of IVR, we would certainly consider it as part of a proposal.

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515) Q: Will the department be willing to expose WMS and KIDS member identifying data to a Contractor SOA-compliant service so we may build our client telephone and renewal contact tracking database at the point of receipt of a call or receipt of a document?

Answer: Yes. Information could be made available to an IVR via an SOA compliant service.

516) Q: "The Contractor must establish and operate a tracking system during the off hours and based on the results the State will determine if additional hours should be added." Does the State anticipate the reverse as well i.e., a decrease in the hours of manned operation if the call volume during outlier hours warrants it?

Answer: Not required.

517) Q: Please clarify which notices will be sent out by CNS and which by the Enrollment Center?

Answer: Renewal packages, and most notices of eligibility determinations and actions on a case, will be sent by CNS. The Enrollment Center will send correspondence such as requests for missing documentation at renewal, or at application for the PAP and FHPBuy-In..

518) Q: Is it the Department's expectation that the tracking of notices (reminders, missing information) sent to members by the Contractor is done within (entered into) the CNS system or tracked in the Contractor's database?

Answer: At this time, the notices that will be sent out by the EC are outreach/follow-up letters to those who are scheduled to renew but have not contacted the EC and those that owe documentation or other information. These will be tracked in the Contractor's database.

519) Q: To what extent will the Department facilitate the use of data from other agencies?

Answer: All information pertinent to processing renewals will be made available via the renewal tool.

520) Q: Please clarify the term "customized notices". How are they being generated?

Answer: CNS generates notices that address the situation and eligibility status of each person applying or renewing. This is what "customized notices" means.

521) Q: How are data stored in relation to a case?

Answer: Individuals are identified by a Client Identification ID, grouped into a "case" as appropriate and stored in a flat file format on the mainframe.

522) Q: This paragraph states "The Contractor may propose an alternative to or augmentation of RFI for such automated verification." Will the Department compensate the vendor separately for any systems development related to improving RFI?

Answer: No.

523) Q: Could the Contractor use Centraport to access NYS laws, desk guides, resource manuals or other knowledge management tools, or would these materials be available only to state staff?

Answer: Resources that are available online to LDSS staff will be available online to Contractor staff.

524) Q: Please provide:

- System diagram for new contract
- List of interfaces: to include description, medium, frequency, source.

Answer: Under development.

525) Q: Do you have current written procedures to support all processes? If so, please provide an inventory and copies of written procedures.

Answer: Please see the Medicaid Reference Guide on the Department's website, under Medicaid/Reference Guides. The Department will provide the Contractor with all relevant and available materials.

Managed Care Health Plan Selection

526) Q: Does the Enrollment Center Contractor have any choice counseling or member education responsibilities regarding health plan enrollment or transfers?
Q: Will the Contractor serve as the managed care enrollment broker for those enrollments processed in the Enrollment Center (for example, will the Contractor maintain an enrollment database, transmit enrollments and disenrollments to the health plans, etc?)
Q: The RFP indicates that the Contractor is responsible for assisting with plan selection and enrollment when members move from FHP to Medicaid, Medicaid to FHP. Please describe the specific responsibilities that the Contractor will have with regard to managed care enrollment.
Q: What responsibility, if any, does the Enrollment Center have in assisting employers or individuals with health plan choices?

Answer: The Enrollment Center will process a plan selection if the enrollee requests to change plans at renewal, or if a person was in fee-for-service Medicaid and now will be enrolling in a Medicaid managed care plan or is now eligible for FHP or CHPlus. If the enrollee knows the plan they want to change into, no choice counseling is necessary. In some cases the enrollee may need assistance selecting a plan. In these cases, the Enrollment Center will have to provide counseling and member education. The EC will not ask at renewal if someone wants to change plans and is not responsible for choice counseling or member education unless asked by the enrollee.

527) Q: If the enrollee wishes to change plans but is in a lock-out period, is the Contractor required to do any kind of follow-up once the lock-out period is over?
Q: If an enrollee requests a change in plans prior to the end of the lock-in period. How and where is this request pended so that the change can be made after the end of the lock-in period?

Answer: Currently, 60 days prior to an enrollees lock-in end date, a letter is mailed to notify them of the ability to change plans. It also states no action is needed if they wish to remain in their plan. There is no current tracking system if an enrollee makes earlier contact wishing to change plans during lock-in, which would cause a special follow-up for this enrollee after the lock-in period ends.

If the enrollee contacts the Enrollment Center for the purpose of changing plans, while they are still in lock-in, the Enrollment Center should refer them to the appropriate Enrollment Broker/LDSS.

528) Q: By what mechanism shall the Contractor submit an applicant's health plan selection to the appropriate LDSS/enrollment broker in the county in which the applicant resides? For example, is a HIPAA compliant Electronic Data Interchange (EDI) interface required?
Q: Regarding the Enrollment Center's health plan enrollment responsibilities for enrollments other than CHPlus: What type of interface or notification is expected between the Center and the appropriate LDSS/enrollment broker in the county in which the applicant resides?

Answer: To be determined.

529) Q: Is the Contractor responsible for sending files to health plans when processing enrollment?

Answer: A Medicaid/FHP application must be submitted first. All applications are registered in WMS. Most of the districts use a State funded COGNON based program for managing workflow. In addition, the State creates monthly reports for each plan of their current enrollees.

530) Q: It appears that this Request for Proposal contains some inconsistencies regarding the services required by the Enrollment Center Contractor compared with Enrollment Broker services. Do you agree that all Enrollment Broker tasks that come through the Enrollment Center should be referred to the Enrollment Broker? Please refer to the following sections of the RFP that delineate the inconsistencies:

Answer: Please note, this question quoted sections of the RFP that seemed inconsistent to the writer. Below are the revised sections which more clearly represent the Enrollment Center responsibilities compared to the Enrollment Broker. In general, the Enrollment Center will not be responsible for plan selection counseling or education unless an enrollee asks to change plan at renewal or if someone is moving between programs and is entering managed care for the first time.

Section V.C.2.g.vi, page 22:

The enrollees are changing programs:

- If a person was enrolled in Medicaid and is now eligible for Family Health Plus, the Contractor shall be responsible for assisting the enrollee in selecting and enrolling in a plan (if the enrollee had not been in a plan when enrolled in Medicaid). The Contractor will forward the necessary information to the Enrollment Broker. If the enrollee was in a managed care plan, and wants to remain in that plan, the Contractor will forward the new program eligibility information to the Enrollment Broker. If a person was enrolled in Family Health Plus and upon renewal, is determined to be eligible for Medicaid, if the person is required to enroll in a managed care plan, and wants to stay in the same plan, the Contractor shall submit the program eligibility information to the Enrollment Broker/LDSS. If the enrollee asks to change plans, the Enrollment Center must provide choice counseling and education and submit the plan choice to the EB/LDSS.

Section V.C.2.g.vii, page 23:

"If an enrollee indicates they wish to change health plans at renewal, the Contractor will assist them in plan selection and will transmit that information to the Enrollment Broker/LDSS/health plan, as appropriate.

Section V.C.5.b.vi, page 33:

"During the web session, applicants will indicate if they wish to change plans. Those that wish to change plans and are not currently in lock-in with a plan will be able to select another plan by contacting the Enrollment Broker or LDSS, as appropriate, for assistance in selecting another plan."

Section V.C.5.c.ii, page 34:

There is no action required if an enrollee chooses to remain in the same plan at renewal. No further action is necessary regarding the plan selection. If the enrollee asks to change managed care plans at renewal, the Contactor will provide plan selection counseling and education, transmit the information, to the Enrollment Broker, LDSS, or health plan in the county for the program for which the enrollee is eligible."

Section V.C.7. (second) d, page 39:

"Submitting the applicant's health plan selection to the appropriate LDSS/enrollment broker in the county in which the applicant resides. The EC will enroll a child directly into the selected CHPlus plan."

530) Q**:** What is the status of the notification strategy to the health plan for members electing to change plans during renewal?
Q**:** What is the current process for notifying a health plan of new enrollments and/or renewals?
Q: If the health plans are not able to accept 834 transactions, is it anticipated that the Contractor would send each health plan an enrollment file or report about each enrollment/disenrollment in format other than 834?
Q: Will the CHPlus plans accept HIPAA-compliant 834 formats for notices of eligibility changes or plan changes?
Q: Do all health plans in New York accept 834 transactions?

Answer: The health plans are provided with a monthly roster from the State which includes all new enrollees, either processed at renewal or at enrollment. This roster is sent 10 days prior to the start of a new contract period. The current Enrollment Broker, provides daily electronic files to the health plans with lists of new enrollees and those who are no longer enrolled in the plan.

Currently eMedNY only accepts 834's from Maximus for enrollment into Medicaid Managed Care plans for a limited number of counties including NYC. WMS does not generate the transactions.

531) Q: Please provide the estimated volume of managed care enrollments that the Contractor will process each month for each program.

Answer: We estimate that approximately 5% of the renewals each month will involve a managed care enrollment action. This will include enrollees switching from fee-for-service Medicaid to Medicaid managed care and enrollees changing health plans at renewal.

Fraud

532) Q: What is the Contractor's responsibility for fraud detection?
Q: The Contractor shall report cases of apparent fraud to the Department. Will the Department provide its current business rules for suspect case identification? Will all case identification be retrospective? Does the Department require any prospective modeling for case marker identification?

Answer: The Contractor is expected to reconcile information that appears to be inconsistent or incomplete before renewing a case. However, the Contractor is not expected to conduct a fraud investigation. The Department will provide instructions on the referral process that the EC will follow if a case appears to involve fraud.

Performance Standards

533) Q: Can the Department further define what is meant by "Enrollment Center must achieve 97% accuracy rate of all renewals."
Q: This paragraph states "Check accuracy of all renewals. The Enrollment Center must achieve a 97% accuracy rate of all renewals." and Section 2.h.ii. (page 23). This paragraph states "ii. Assure the accuracy and completeness of the information collected at renewal by telephone and by mail. The Contractor shall not be paid for renewals that are ineligible due to an error on the Contractor's part. Eligibility errors must be kept to less than 3 percent of all renewals processed by the Contractor in a month."
- Do these standards include renewals involving special circumstances (as described on page 21), and "cross program issues" as described on page 14?
What are the criteria for determining the accuracy of potential eligibility determination?

Answer: The standards apply to all renewals done by the EC. The accuracy rate is calculated by the Department. If a renewal is sent for State staff sign-off and is incomplete or incorrect, this will count as an error. The total of those done correctly will be divided by the total number of renewals completed for the month. Accuracy Rate = Monthly Correct Renewal/ Total Monthly Renewals.

534) Q: The RFP is silent to requirements related to screen capture for quality monitoring purposes. Is this an oversight? If so, what percent of calls received by the Call Center does the Department require to be screen captured?

Answer: Screen capture is not a requirement of current hotline operations. A bidder may propose use of screen capture if their experience shows it to be effective in quality assurance.

535) Q: We understand NYS DOH's expected service levels and performance measures as stated throughout the RFP. Please provide the service levels experienced through the current independent hotlines.
Q: Can you describe the extent of each of these requirements already being performed for the State?
The RFP indicates that the Contractor shall meet industry standards for quality assurance. Please specify the quality assurance standards that the Contractor is required to achieve.
Q:This Section States that: "The Contractor shall meet industry standards for quality assurance. Any alteration of the frequency or strategy for monitoring the Call Center staff shall only be made with prior approval of the Department."
Q:: Does the Contractor define industry standards or will the Department define them?

Answer: The Contractor must meet the standards set forth in section V.C.1.c of the RFP. The current CHPlus hotline experiences an abandonment rate of 2.7% and has an average hold time of 40 seconds. The quality assurance methods shall be proposed by the bidder as stated in section V.C.8. If a change is going to be made by the Contractor after contract implementation, the Department requires prior notification to ensure continuous quality assurance.

536) Q: Please describe how your quality assurance process for accuracy on renewals is performed.

Q: The RFP states that the Contractor must follow industry quality assurance standards for enrollment processing. Does the Department have any specific standards for QA that should be met?

Answer: Currently supervisors of LDSS workers perform quality assurance on case determinations. The Contractor must meet the standards set forth in section V.C.2.f of the RFP. The quality assurance methods shall be proposed by the bidder as stated in section. Examples include 1) auditing a percentage of monthly renewals for accuracy and completeness or 2) developing corrective action plans targeted to a specific worker, or subject area.

Miscellaneous

537) Q: In an effort to benefit and help vendors truly understand current Department and Contractor processes to assess how to better serve as the Enrollment Center, will the Department open a procurement library, prior to the bidder's conference, containing key materials and information related to the Enrollment Center contract? We have provided a list of items to ease the process of identifying needed information.

Answer: We are providing this information as part of the Q and A's.

538) Q: Please provide marketing materials produced by the State and marketing materials produced by current Contractors and other entities

Answer: The Child Health Plus (CHPlus) brochure (Attachment 8) includes the location of enrollment entities and eligibility criteria for the program. The CHPlus postcard (Attachment 9) is a tool used to collect information on New Yorkers who are interested in enrolling. The information is referred to facilitated enrollers. The CHPlus flyer (Attachment 10) is includes the hotline number and covered services for CHPlus. The Family Health Plus brochure (Attachment 6) lists who may apply, the FHP hotline number, and what services are covered. The Consumer Guide to Medicaid Managed Care in NYS (Attachment 11) is a guide to the plans available and the services the plan provides, and provides contact numbers. The 60-day Manage Care booklet (Attachment 12) is a guide to be used by those enrollees who are required to be enrolled in managed care plan, and have 60 days to select which plan they wish to enroll in.

Marketing materials produced by current Contractors: None.

539) Q: Please provide a list of relative stakeholders.

Answer: Stakeholders of the Enrollment Center include: enrollees/applicants, the State, insurance companies, policy advocates, etc. Additional details are not required to prepare a response to the RFP.

540) Q: Does the Department have specific requirements for the call center availability in the event of a disaster (local or regional)?
Q: Does the Department have specific requirements for recovery of application processing services in the event in the event of a disaster (local or regional)?
Q: What happens to the Enrollment Center's responsibilities if the EEDSS system is down or unavailable?

Answer: This depends on the type of disaster. In the event of something like an ice storm, flood or other weather-related problem, local districts currently are expected to take information manually when WMS is down, and enter it when the system is again available. To avoid forcing clients to make an unnecessary second call, especially if anything were to happen to the system in mid-interview, the Contractor will be expected to have a back-up manual or disaster-recovery process.

In the case of 9/11, special processes were developed by all agencies, individually and through SEMO, to respond to the magnitude of the disaster.

Disaster Recovery Plans for each call center. The Medicaid and FHP hotlines' disaster recovery plans are included in the State's Disaster Recovery Plans.

541) Q: What is involved in managing requests for presumptive eligibility?
Q: Where will the authorization numbers come from?

Answer:

- If a child is found presumptively eligible (PE) by a Qualified Entity (QE), the QE will call a NYSDOH designated toll-free number to obtain a PE authorization number/name and record it on the appropriate form. NYS DOH maintains a database with authorizations.
- The QE must assist with the completion of DOH-4220- Access NY Application for ongoing Medicaid, including document collection. PE cannot be authorized unless this application is completed and received by the district

542) Q: What is involved in granting good cause exceptions?

Answer: "Good Cause" refers to instances where the recipient has a good reason for the provider not to bill third party insurance, allowing the bill to be paid only by Medicaid. When third party insurance is billed by a provider, the insurance carrier sends the policyholder an "Explanation of Benefits", also referred to as an EOB or EOMB. This is to make the policyholder aware of medical services that have been provided by their insurance company. There may be an instance where a family member is covered by the third party insurance and also Medicaid, but the patient does not want the policyholder to know that they received a particular medical service. Some examples would be:

- A woman may not want her spouse to know that she is receiving family planning services, for fear that her husband will object.

- A teenager may not want her parents to know that she is receiving family planning services for fear of negative consequences (i.e., severe punishment, being asked to leave the home, etc.)

- A victim of domestic violence may not want his/her abuser to know any information about him/her.

These are only examples and other situations may be presented that also qualify for "good cause".

543) Q: Please describe the current process for issuing certificates of credible coverage. Are these physically mailed to members?
Q: Is a 'certificate of creditable coverage' used today?

Answer: The State sends the letter/certificate to the former recipient, based on a file from eMedNY of people whose Medicaid/FHPlus coverage has been discontinued.

544) Q: The RFP states that the Contractor must "respond to and comply with all auditing requirements from CMS and state agencies." What state agencies have these auditing requirements and can the Department describe them?

Answer: Audits are routinely conducted by the Office of the State Comptroller, the Division of the Budget through a Contractor, and can be conducted by the Office of the Medicaid Inspector General. The Office of Health Insurance Programs also conducts its own audits. With respect to Medicaid eligibility, auditors examine whether the information in the case file supports the eligibility determination, and whether the determination was correct.

Record Keeping and Privacy Concerns

545) Q: Should detailed records of actions taken with enrollees be maintained for 7 years from the date of the action or 7 years after closure of the case file?

Answer: Seven (7) years after closure of the case.

546) Q: This section states that the Contractor shall keep a case file for seven years from the effective date of closure. Please confirm that a case file can be electronic (scanned) documents.

Answer: The case file can be electronic.

547) Q: Is it expected that all data is to be available online?

Answer: WMS and eMedNY are expected to contain all data necessary to define client eligibility. The renewal tool will produce a record of the interview and data gathering process. All data stored electronically must be retrievable. All data collected as part of the renewal process shall be stored electronically, though not necessarily on-line.

548) Q: Who handles document retention in the present operations?:
-Is a case file stored locally or is a third-party vendor used?
-If a third-party vendor is used please identify who, and the cost associated with retention.
-If an electronic version of the case file is created, can it serve as the retained audit copy (can the paper be destroyed sooner than 7 years if electronic copy is in place)?

Answer: Currently, the LDSS is responsible for retaining the documents for the cases it processes. The methods vary by district. An electronic version of the case file can serve as the retained audit copy.

Reporting

549) Q: Please provide an inventory of all current reporting and the tools used to manufacture each report.
Q: Please provide sample report formats for the Telephone and Mail-In Renewal System.
Q: Where is the necessary data for reporting requirements? Would it reside in the Contractor's database or could it include State databases?
Q: How many ad hoc reports should bidders assume the Department will request each month?
Q: Please provide examples of the type of ad hoc reports that the Department will require the Contractor to generate.
Q: What is the required turnaround time for ad hoc reports?

Answer: The required data to be reported for renewals as listed on page 24 of the RFP include data points which should be stored within the Contractors renewal tracking system. Sample reports are unavailable. Reports shall be supplied to the Department in Microsoft Excel and Adobe formats. The number of adhoc reports is unknown at this time; however the Department will work with the Contractor on time frames and formats upon award. Currently, the LDSS do the renewals. Communication between the LDSS and Contractor will be necessary at times.

Fair Hearings

550) Q: What is the Contractor's role in the fair-hearing process?
Q: Are required documents for fair hearings available through State systems or must the Contractor maintain its own system for this purpose?
Q: Does EEDSS or WSMS provide the capability to maintain notes about conversations with the client, or is it assumed that the Contractor will provide a CRM tool?
Q: Would the Department expect this file or report to be generated in the Contractor system or the state system?

Answer: The Contractor will be responsible for maintaining complete records and assembling the documents. The State will provide oversight and represent the Enrollment center at Fair Hearings Some items would be available on State systems and others would be in the case record retained by the Contractor. The Contractor would be responsible for information necessary to supplement that provided by the State systems.

Proposal Requirements: Technical Proposal

551) Q: The RFP states that each reference must satisfy the Lobbying Statute as stated in Section VIII.L. Did the RFP intend to reference Section VIII.P instead?

Answer: Yes.

552) Q: Please clarify what is meant by "level of staff".

Answer: Level of staff refers to project managers, supervisors, call center representatives, application assisters, or other career bands of employees.

553) Q: How should the response to these requirements differ?

Answer: The second half of (g.) is repetitive of the question asked in (f.). The response may be the same.

554) Q: Does "key staff members" only include Project Manager, Deputy Project Manager and Project Supervisors?

Answer: Key staff members include the Project Manager, Deputy Project Manager, Project Supervisors, and any other managerial and/or procedural decision making position as designated by the Contractor.

555) Q: Shall bidders restate each entire RFP requirement shown in Section V when responding to requirements in Section VI? Or should bidders merely be certain to address the Section V requirements without restating them?

Answer: The bidder should address the Section V requirements within their response to the items listed within Section VI. It is not necessary to restate the entire requirement as long as your response clearly reflects the issue you are addressing.

556) Q: Given that the RFP envisions a centralized renewal process, please elaborate on the Department's expectations regarding the ongoing role of health plans, facilitated enrollers, and LDSS employees in the renewal process.

Answer: In year one, CHPlus health plans will continue their current roles in the renewal process. Once CHPlus renewals are included in the EC responsibilities, plans will focus on new applications. FEs too will focus on new applications and LDSS's will focus on new applications, and renewal for those that do not self-attest and, therefore, cannot renew through the EC.

557) Q: Please provide detailed documentation on what the State system looks like now and any anticipated enhancements planned for the next year or so that would substantively alter the Contractor technical solution.

Answer: None

558) Q: Please clarify what is meant by "division".

Answer: Division as used in this statement means the department/bureau, where the staff is located within the Contractor's organization.

559) Is the employer or the enrollee responsible for returning the (Family Health Plus Buy-In) form to the Contractor?

Answer: See **08ADM-01** on the Department website, under Medicaid/Reference Guides/Library of Official Documents.

560) Q: Is the reference to "applications from designated entities as described in Section V" intended to mean "Section V.C.7?"

Answer: The reference to "applications from designated entities as described in Section V" is intended to mean "Section V.C.7."

561) Q: Please clarify what is meant by "reporting process determinations".

Answer: "Reporting process determinations" is the Contractor's method of providing *feedback* on the pilot project.

562) Q: Is the Contractor required to integrate elements of the Department's existing fraud detection system for reporting "apparent fraud to the Department"?

Answer: No. The Contractor is expected to reconcile information that appears to be inconsistent or incomplete before renewing a case. However, the Contractor is not expected to conduct a fraud investigation. If a case appears to involve fraud, the Contractor will have instructions on referring it for investigation.

563) Q: Are printed copies of scanned images acceptable documentation to provide to the local districts for a State Fair Hearing?

Answer: Yes

564) Q: If printed copies of scanned images are not acceptable documentation for purposes of a State Fair Hearing, does that mean that hard copy documentation needs to be maintained?

Answer: N/A

565) Q: How is this response different from the response required for VI.B.4.f (pg.44)?

Answer: The response to these two sections may be the same.

566) Q: Please confirm that the bidder be alleviated of performance standards and service level agreements if there is an access issue with State of New York Systems which prohibits the bidder from performing those necessary functions.

Answer: The Contractor will not be held responsible for systems issues due to State maintenance issues. However, the Enrollment Center must create back-up methods should there be an access problem. The reason for the system issue will determine the Contractor's liability. In the event of something like an ice storm, flood or other weather-related problem, the Enrollment Center will be expected to, as are local districts currently, take information manually when the system is down, and enter it when the system is again available. To avoid forcing clients to make an unnecessary second call, especially if anything were to happen to the system in mid-interview, the Contractor will be expected to have a back-up manual or disaster-recovery process.

In the case of 9/11, special processes were developed by all agencies, individually and through SEMO, to respond to the magnitude of the disaster.

Proposal Requirements: Cost Proposal

567) Q: What adjustments would the Department make for increases in postal rates during the term of the contract? Would the Department consider making postage a pass-through payment?
Q: How will reimbursement of postage be handled?

Answer: The RFP includes instructions on trending costs forward. We will not make this a pass-through. All prices/costs must be included in the proposed per unit price.

568) Q: Since the fixed rate the Bidder is required to propose is based on data and work effort described in the RFP, what process will be followed if the State data/assumptions are significantly different from actual?

Answer: Bidders should propose per unit prices based on the volumes provided. Those prices address a wide volume range and will be used to select and pay the Contractor.

569) Q: What is the expected award date?

Answer: The expected award date is June 2009.

570) Q: When does the "start-up" time period begin? At award of contract? At some point after?
Q: Are the start-up periods linear (i.e. Call Center 3 months then the Renewals 6 months etc.) for a total of 20 months or are they meant to be concurrent, or a combination of linear and concurrent? The chart approximates start-up periods for each component. Please confirm that it is the Department's intention that each of these start-up periods would be consecutive rather than concurrent?
Q: Is the schedule provided on page 52 concurrent or consecutive lengths of start up periods? In other words, what is the trigger (e.g., contract execution date, operations start date, project completion date, etc.) for the start-up period for each project listed?

Answer: The start-up time period for each project will begin on different dates. They will be a combination of linear and concurrent. The Call Center and Telephone and Mail-in Renewals will begin start-up on the date of contract execution; others will begin at some point after.

571) Q: Please confirm that the length of start up period is from notification by the Department that a program will be implemented and not from the start of the contract. Further, please provide start up dates that should be used for purposes of calculating prices.

Answer: Correct, the start up period will begin as soon as the contract is executed. The Department will notify the Contractor when that occurs. The Call Center and telephone and mail-in renewals will immediately begin start-up activities. The remaining start-up dates are dependent on the availability of funds and progress on the first two projects. The bidders shall provide bid prices as if all projects were to be implemented in year one.

572) Q: The RFP states that the start-up costs should be included in year one unit pricing. Does the time frame of year one, months 1 – 12, include the three-month start-up period? Or, is there a three-month start-up period that is then followed by the first 12 months of the contract? In this later case the end of "year one" would be 15 months following the contract award. Please confirm how the time lines for each year of each project will work.

Answer: The start-up periods for the Call Center and the Renewal function are included in months 1 – 12.

573) Q: Please clarify/confirm the following as it relates to the telephone and mail-in renewals and the phase-in of the program:

- During the first six months the Contractor will not process any renewals.

Answer: If the Contractor completes start-up activities prior to the end of the start-up period, subject to Departmental approval, the Contractor may begin the activities of that project.

- During which month and year should the Contractor expect the program to be at full implementation and processing the 70,000 to 100,000 applications?

- **Answer**: The date of full implementation will be determined based on progress and the availability of funds.

- For each month of the two year pricing period, please provide a volume estimate to be used in arriving at the bid form amount and the price used for scoring the cost proposal.

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Answer: Please see the RFP for the volume estimates. The Department expects bidders to propose the prices.

574) Q: In which month of the first year should the Contractor expect to begin administering the premium assistance program?

Answer: If the premium assistance program is implemented in the first year, it will be the last quarter of the year. However, it might not be implemented until the second year.

575) Q: The start-up period for the Development of Materials is 1 month. Does this period include developing materials from concept to final approval as well as production and printing of the materials?

Answer: No. The start-up period for Development of Materials is to acquire the necessary equipment and supplies, as well as staff, if applicable, before the project start date. The Department will work with the Contractor to create a product deadline which will include the developing of materials from concept to final approval as well as production and printing.

576) Q: What weights will the State apply to the tiers for each cost component?

Answer: As stated in the RFP, the weights are used by the State for the normalizing and scoring of the bid prices. The specific information will not be provided at this time.

577) Q: Please confirm that unit pricing will be different for each unit in each tier (i.e. from 0 – 10,000 units one rate will apply and then from 10,001 – 15,000 another rate will apply. Please confirm that at the higher volumes all units will NOT be priced at the lower unit rate (i.e. if volume reaches 15,000, all units up to 15,000 would be priced at the lower unit rate).

Answer: The per unit pricing will be based upon volume. We will not be blending tier prices. The higher unit price will apply if the total volume provided is in that range.

578) Please clarify the cost evaluation methodology "Price will be scored using an average of the three tiers below based on expected but not guaranteed volume". If a range is given for "expected volume" (i.e. 70,000 to 100,000 renewals per month) what volume will be used to compute the bidder's score? If there is an expected volume per month that is in the lowest volume tier, will the pricing be evaluated at just this tier (and not using the other tiers)?

Answer: No, the pricing will be evaluated based on a weighted average of the tiers.

579) Q: Under the Cost Worksheet description for each category, there is a sentence that reads: "The price will be scored using an average of the three tiers weighted based on expected, but not guaranteed volume." Can you elaborate with an example to demonstrate what you mean by "using an average of the three tiers weighted"? As an example, if for Statewide Call Center a bidder submits $a1, $a2, $a3 as per unit bid price for the three bands, then would the bidder's price used for scoring be ((a1+a2+a3)/3)*70000*12?
Q: Cost Worksheet (Attachment J) has 7 sub sections with band-based price for each sub section. How would prices from Attachment J be converted to "z" (= total cost for bidder) used on page 58? Can you provide the exact formula?
Q: While calculating Total Cost for bidder "z" - how many years of price will be considered… 1, 2, 5, or 7? If the price for more than 2 years is to be considered; then would the Attachment J prices will be inflated by 4% beyond year 2 for all categories?
Q:The RFP states that at the conclusion of the evaluation of both technical and price proposals and oral presentation and/or site visits, the Department will identify the bidder that best meets the Department's needs. Will the Department score both the orals and the potential visits? If yes, how will it factor those scores into the final evaluation?

Answer: The agency is not required to disclose to offerers either the detailed evaluation criteria or the relative importance or weight of the various individual Technical Evaluation measures. Bidders need to refer to Section C, Cost Proposal, 4., Section 2: Cost Worksheet of the RFP which includes the following language:

"The Cost Worksheets include the first two years of each project of the contract.
Please note that until the proposals are reviewed, the bidder should assume that the

Call Center, telephone and mail-in renewal assistance, and the premium assistance program will be implemented in the first year of the contract. Depending on the progress of these projects, subsequent projects will be added in later years. The pricing for contract years 3 through 5, and any subsequent contract renewals, will be subject to annual price increases of the lesser of four percent (4%) or the percent increase in the National Consumer Price Index for All Urban Consumers (CPI-U) as published by the United States Bureau of Labor Statistics, Washington D.C. 20212 for the twelve (12) month period ending ninety (90) days prior to each contract renewal date. The increases will be based upon the per unit price for months 13 through 24 for each category of service as established in the bidder's cost proposal and resultant contract."

580) Q: Given the proposal solution, NYS DOH's right to terminate for convenience, or to cancel or delete services, without further obligation makes it difficult for he Contractor to recoup the start-up costs if the contract is terminated prior to the end of the first year. Will NYS DOH consider an early termination fee if termination or an alternative payment schedule?

Answer: In the event of cancellation without cause by the State, the State agrees to negotiate a payment based on time, materials or other documented expenses directly attributable to the Contract actually expended by the Contractor.

581) Q: The RFP states that an assumptions section is not to be included, however there are some standard terms and conditions that we did not see in the RFP that we would expect to be in a resulting contract in order to be sure that our respective obligations are understood including but not limited to, warranty that the services will be performed in a workmanlike manner, exclusion of implied warranties, a defined acceptance process, change order process, definition of roles and responsibilities for NYS DOH, payment terms (e.g., net 30), etc.). Should bidders identify these items to NYS DOH in a contract clarifications section of the proposal or through some other means?

Answer: No. Except to the extent provided in the response to Question 627, the Department feels that these assumptions are fully covered in the project specifications section of the RFP.

582) Q: Please confirm that the 70,000 call estimate does not include any renewal calls or calls related to the Premium Assistance Program or the FHP Buy In.

Answer: The 70,000 call estimate does include current calls received in regards to the Premium Assistance Program and Family Health Plus Buy-In. Telephone renewals are currently not performed; therefore they are not included in the 70,000 estimate.

583) Q: For billing purposes for the Call Center component, a unit is defined as a call that is answered by a live person or an answered phone call back in return to a message left at the Call Center. If the Contractor proposes to include outbound reminder phones calls as part of the solution, can the outbound calls be considered a "unit" for billing purposes?

Answer: This question combines the "unit price" for the call center (first sentence) with the unit price for a renewal (second sentence).

584) Q: If the Department determines that outbound reminder phone calls cannot be considered as a unit" for billing purposes, how would the Contractor be reimbursed for the cost?

Answer: Outbound reminder phone calls related to renewal are considered part of the cost of a renewal and should be factored into the proposed price.

585) Q: For billing purposes for the Call Center component, a unit is defined as a call that is answered by a live person or an answered phone call back in return to a message left at the Call Center. If the Contractor proposes to include self service IVR calls as part of the solution, can the self service calls be considered a "unit" for billing purposes?

Answer: The costs of IVR should be incorporated into the per unit price for the Call Center. The definition of "unit" remains as in the RFP a call answered by a live person or a returned phone call.

586) Q: The pricing structure is based on calls answered by live agents or when an agent connects live with a person on a call back. This pricing structure leaves very little incentive for vendors to make use of self-service options. It may be in the best financial interest of the Department to consider a pricing structure that reflects both live response and automated responses to call volume.

Answer: The Department expects that the Call Center will use some form of IVR which should be factored into the per unit cost. .

The Department did not envision IVR to be used for telephone renewal. However, if based on experience, a bidder wishes to propose the use of IVR at renewal, we would carefully assess its use. And it should be factored into the per unit price for the Renewal function.

587) Q: Please confirm that the Contractor will not be responsible for any calls during the first three months of the contract and responsible for all calls beginning in month four of the contract.

Answer: The Contractor will not be responsible for any calls during the first three months of the contract and will be responsible for all calls beginning in month four of the contract.

588) Q: Will the Contractor be able to bill for renewals processed and pended due to missing information needing to be submitted by the enrollee? How long does the Contractor hold the pended renewal before it can bill for it?

Answer: The Contractor may only bill for renewals submitted for final determination to the State, or those pended for further documentation for more than ten days past the due date.

589) Q: Please confirm that the cost unit definition for telephone and mail-in renewals is based on individual renewals.

Answer: It is not based on individual renewals. It is based on case renewals.

590) Q: The RFP states that currently local districts process 70,000 to 100,000 renewals per month. Does this include renewals where enrollees are not able to self-attest? Will the Contractor be responsible for renewals of any enrollees who cannot self-attest?

Answer: Initially, the Enrollment Center will process renewals from people who can attest to income and resources. The numbers in the RFP include recipients who cannot attest. However, the majority renewing can attest.

591) Q: What is the estimated time to process each type of renewal—phone, mail-in and web-based?

Answer: We expect that it will take less than 30 minutes to process a complete mail-in renewal. However, the process can take more time from start to finish if it is necessary to obtain documentation. We have no experience with telephone or web-based renewals.

592) Q: How are web-based renewals addressed in this cost form versus VI.C.4.e?

Answer: VI.C.4.e is a copy of the table used in the cost form. The cost form, or Cost Worksheet (Attachment J), is broken down into a year one bid price column which shall include start-up costs, and a year two bid price column which shall not include start-up costs.

593) Q: What is the estimated proportion of phone versus mail-in versus web-based renewals?

Answer: Unknown.

594) Q: Please provide anticipated monthly volume for years one and two to be used for calculating the bid form amount and for the scoring of the cost proposal. (VI.C.4.c - page 54).

Answer: Please see the RFP for volume information.

595) Q: Will the Contractor be responsible for any lock box fees and bank charges associated with this service (Family Health Plus Buy-In) and, accordingly, build them into their price?

Answer: The Contractor is responsible for transferring funds it receives from enrollees to the appropriate party. The Contractor should factor in all costs associated with ensuring that the money it receives will be successfully transferred.

596) Q: The cost worksheet for FHP Buy-In states "the first price is for processing applications for the subsidized people applying…" Does this include processing applications for those who are ultimately found to be ineligible for subsidized enrollment?

Answer: This price includes both those who are determined eligible or ineligible. The first price is for the assessment of eligibility. The second price is for collecting any payments necessary from the enrollee or employer.

597) Q: What reimbursements does the Enrollment Center need to authorize for the FHP Buy-In program?
Q: Please clarify the process for authorizing reimbursements for the FHP Buy In program.

Answer: Subsidized FHP Buy-In payments made in full by the employer/enrollee may be reimbursed by the EC through eMedNY.

598) Q: Please define "each transaction of funds between … the employer and the Department". Is this for each individual or group premium paid?

Answer: The EC will be responsible for collecting and transferring the applicable employer premium contribution to the State. This must be at least 70% of the premium for each enrolled employee.

599) Q: Please indicate the number of pages to be used for each year for the bid amount and for cost proposal scoring. (VI.C.4.f) (Development of Materials)
Q: Will the Contractor be responsible for any printing or postage costs associated with this function? If so, please provide estimated volumes. (Development of Materials)
Q: The bidder should propose a price for the development of fliers/brochures/other media based on a Per Page Price. Is it possible to propose alternate pricing for other media (e.g., audiotape, videotape, etc.) since a Per Page unit cost may not be applicable?
Q: Should printing and postage costs be included? If yes, what are the estimated volumes and frequency?

Answer: We do not know how many pages will be requested. We can expect it to be no more than ten pages per year. There may be printing costs involved. Mailing costs should not be factored your proposal in this category. Mailing costs should be included in the Call Center proposal. The media which may be required to be developed by the Contractor in this section is specific to paper media.

600) Q: Please clarify that the cost form applies to Year 2 only and no Year 1 cost information is required. (VI.C.4.g)

Answer: The cost form, or Cost Worksheet (Attachment J) does include both Year 1 and Year 2 cost information for web-based renewals.

601) Q: Please provide estimated time to process for each program. (VI.C.4.g – web based renewals)

Answer:
Renewal: We expect that it will take less than 30 minutes to process a complete mail-in renewal. However, the process can take more time from start to finish if it is necessary to obtain documentation. We have no experience with telephone or web-based renewals.

Application: An interview takes between 30-60 minutes. Any necessary reconciliation of documents and data takes additional time. The required timeframes for eligibility determinations are 30 days for pregnant women and children, and 45 days for adults.

602) Q: The cost proposal requests a year one price for this service, but the RFP states that this service will begin in subsequent years. Please clarify.
Q: The RFP states that if the new application/renewal programs do not start-up until after year two, then the year two cost will be taken and inflated accordingly. However, start-up costs are to be included in year one and the Department expects year two costs to decrease relative to year one. Can the Department provide more clarity as to the timing of these programs and how start-up costs can/should be recouped?

Answer: The bidders shall provide bid prices as if all projects were to be implemented in year one. If the project is not implemented until subsequent years, for example year three of the contract, the bid prices will be inflated by the lesser of four-percent or CPI-U.

Method of Award

603 Q: Please provide the relative weighting of the various components of the technical evaluation.

Answer: See RFP p. 57

604 Q: Will each program component approach be evaluated with equal weight (e.g., call center approach is scored with the same weight as processing new applications and other renewals)?

Answer: The State will not be providing this information at this time except to say the various components are not being weighted equally.

605) Q: The RFP states that at the conclusion of the evaluation of both technical and price proposals and oral presentation and/or site visits, the Department will identify the bidder that best meets the Department's needs. Will the Department score both the orals and the potential visits? If yes, how will it factor those scores into the final evaluation?

The RFP states, "At the conclusion of the evaluation of the technical and price proposals, and oral presentation and/or site visit, if necessary, the Department will identify the bidder that best meets the Department's needs as reflected in the scoring/evaluation." There is no score for the oral and potential visits as these are intended to ensure the Department's understanding of proposal components. The score is based on the cost and technical proposal points awarded.

Administrative Issues

606) Q: Will the DOH create a distribution list and e-mail interested bidders when there are RFP amendments or other notifications?

Answer: We will post any RFP amendments or other information, on the Department's website.

607) Q:: Will DOH provide a list of all persons/firms attending the bidders conference?
Q: Will DOH post any presentations prepared by DOH and delivered at the bidders conference on the DOH Web site?

Answer: These are posted on the Department's website at www.healthj.state.ny.us/funding/rfp/0808040239.

608) Q: Is there is a transcription of the conference, will DOH post the transcription of the bidders conference on its Web site?

Answer: No, the Department will not be posting the bidders' conference transcript.

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609) Q: In consideration of the various warranties, remedies, cure, and notice periods presented in Appendix A and requested in our other questions, we request that the DOH accept a performance bond in lieu of the letter of credit.
Q: Would the State consider an alternate financial assurance to the requirement for a Standby Letter of Credit in the required amount of $1,000,000, such as a performance bond?
Q: What financial assurance other than a letter of credit would the Department accept? A letter of credit would cost the Department money because a Contractor must include letter of credit fees in its pricing. Additionally, other methods better protect the Department against poor performance, including excellent Contractor qualifications, thorough testing of systems and financial penalties for delays.

Answer: No. As stated in Section VIII G. of the RFP, the Department will only consider a letter of credit.

610) Q: This section mentions liquidated damages, however there is no description of when LDs would apply and how they would be computed. Please confirm that there are no LDs for this contract.
Q: How does this section relate to the monthly retainage?
Q: What are the liquidated damages—amount and type?

Answer: See RFP, p.62, section g..Bl and section I.

611) Q: Per the RFP, the monthly claim for each core performance category (Call Center, renewal, etc.) will be reduced by ten percent (the "retainage") which can be billed to the Department the following month if the performance standards are met. In order to receive payment for the retained amount in any core performance category, all performance standards for that category must be met. Are the performance standards limited to what is outlined in the

following sections?

a. Statewide Call Center - V.C.1.c – Response Times (Pg 8)
b. Telephone & Mail-In Renewal System - V.C.2.f – Renewal Processing Standards (Pg 21)
c. Premium Assistance Program – V.C.3.b.vii (Pg 29)
d. FHPlus Buy-In – V.C.4.c (Pg 31)
e. Web-Based Renewal System – V.C.5.d (Pg 35)
f. Marketing & Outreach Materials – V.C.6 (1st paragraph Pg 37)

Answer: The RFP includes performance standards based on current knowledge. The Department reserves the right to modify performance standards based on the implementation and experience of the Enrollment Center. Modifications will be developed in consultation with the Contractor.

612) Q: What are the performance standards on which the Processing New Applications retainage will be based?

Answer: See RFP pages 37-40.

613) Q: Please clarify what requirements are included in "perform fully and completely all requirements of the Contract."

Answer: The Department requires the successful bidder to perform all the services as required by the RFP and resulting contract.

614) Q: Will the Contractor have any appeal rights related to decisions made regarding performance standards in any given category which may result in the forfeit of the 10% retainage.

Answer: No.

615) Q: How would the Department quickly resolve disputes with regard to whether the Contractor has satisfied performance measures?
Q: Will NYS DOH include an informal dispute resolution provision in the final contract?

Answer: The successful Contractor and DOH agree that it is important to resolve any disputes regarding the performance of the services to be performed, or otherwise arising under the resulting contract, expeditiously. Accordingly, the successful Contractor and DOH agree to meet in good faith to resolve any disputes, and in the event any dispute cannot be promptly resolved at the operational level, either party may request a meeting with senior management of the other party, which meeting shall be held within ten (10) business days or sooner in the event a dispute threatens the performance of a material portion of the services or the resulting contract.

616) Q: The DOH will reduce contactor payments by 10% for retainage against proven performance. DOH has also suggested a goal of 5% woman-owned business participation and 5% minority business participation. Some MBE/WBE firms have indicated that since they are small businesses as well, the retainage will negatively impact their ability to pay their employees. Will DOH waive the retainage for the percentage of work performed by MBE/WBE subcontractors?

Answer: No.

617) Q: The RFP states that the Department will not pay the Contractor for any duplicated renewals. Does this mean duplicated renewals within the Contractor's control or would this include renewals that the LDSS or a health plan may perform in situations where the enrollee has submitted renewal documentation in both places and not made the Contractor aware?

Answer: This is only in the case when the duplicate is not within the Contractor's control

618) Q: Please clarify what is meant by "Paper and electronic transactions, including transfers are eligible for payment."

Answer: Both electronic and paper renewals, including those with enrollees changing programs, are eligible for payment.

619) Q: Would the Department agree to extend the contract only with the consent of the Contractor? Consent by both parties to a contract extension ensures a continuing collaborative relationship and allows appropriate adjustments based on circumstances that were unforeseeable at the time the parties entered into the contract.

Answer: Yes. The Department would agree to obtain the consent of the Contractor before extending the contract.

620) Q: Would the Department provide the Contractor with at least sixty calendar days' notice of termination without cause to facilitate a smooth transition of services? The time sensitivity typically associated with termination with cause is not relevant to termination without cause. Thus, a greater notice period for termination without cause facilitates a smooth transition of services without increased risk.

Answer: No.

621) Q: Please provide/describe the transition plan (e.g., the LDSS' roles, length of transition period, etc.)
Q: Please provide a copy of the Transition Plan referenced in RFP Section VIIII, Administrative Issues, Item L. We will need this for work plan development and planning purposes for the proposal.
Q: What is the plan for transitioning work from the current Contractors to the new Enrollment Center Contractor?
Q: Please clarify how this requirement is applicable to this contract.
Q: Can the Department provide a copy of each Contractor's turnover plan?

Answer: The transition plan will be developed with the successful bidder and will determine mutually acceptable roles, transition lengths, etc.

622) Q: Will the Contractor's proposal be incorporated into the final contract? What will be the order of precedence between all documents that will be incorporated into the final contract, including the specific appendices?

Answer: Yes. Per the Appendices list in the RFP, the bidder's proposal and any bid forms and/or attachments will become part of the final contract, Appendix C.

General Questions

623) Q: Many times responses to questions lead to more questions. Would DOH consider one additional round of questions based solely on the response to bidder questions?

Answer: No.

624) Q: Can DOH provide an indication of the project's funding and is this procurement at risk due to budget shortfalls?

Answer: The Enrollment Center is budgeted at $34 million for SFY 2009-10 and $42 million in SFY 2010-11. Funding for future years will need to be negotiated in future State budgets. Funding for State contracts is always subject to the availability of funds. While the Enrollment Center is funded for the first two years and we do not anticipate funding shortfalls, the Department cannot guarantee the availability of the funding.

625) Q: Are there any specific Woman-Owned and/or Minority-Owned Business revenue goals associated with this RFP similar to quantified goals in other Department RFPs?

Answer: Yes. The suggested goal is 5% for each.

626) Q: Given that the compensation is based on unknown volumes, would the Department agree to a minimum amount of compensation if volume of work falls below 92% of the estimated volume provided for in the RFP or a volume agreed upon by the Department and Contractor prior to contract start date, thus allowing proposers to provide the best pricing?

Answer: No.

627) Q: Would the Department agree to limit the Contractor's liability to the Contractor's revenue from the contract?
Q: Would the State agree to limiting the Contractor's liability to the Contractor's revenue from this Agreement?
Q: Would the State agree that neither party will be liable for special, indirect, incidental, consequential, punitive or exemplary damages (including negligence) strict liability, or otherwise, even if the party has been advised of the possibility of such damages?
Q: What is the Contractor liability if the State staff fails to perform in a timely manner?
Q: Would the State consider amending this Article to include a cure period of 30 days, in the event of a State notice of default, for the Contractor to cure the default condition?
Q: Would the State consider the inclusion of a Termination for Convenience Article?
Q: Would the Department clarify that it is entitled to terminate the contract only as a result of Contractor's material failure (and not just a minor failure) to conform with contractual requirements or comply with any applicable law, regulation, or rule?
Q: May Contractor have at least thirty days to cure a breach of contract? Permitting the Contractor to improve performance prior to termination saves the Department the cost and inconvenience of reprocurement.
Q: Will NYS DOH include a minimum 30 day opportunity to cure prior to termination for any reason to encourage resolution of issues, and the completion of performance under the contract?
Q: Will NYS DOH accept a limitation of liability equal to the amount paid by DOH to Consultant under the Contract for the six (6) month period just prior to the claim as well as exclusions for

indirect damages, loss of records data, loss of profits revenues or expected savings and a disclaimer of all implied warranties?

Q: Will NYS DOH include an indemnification provision in the final contract that clearly states the parties' indemnification obligations and the process to be followed should a claim arise or appear to be likely?

Answer: INDEMNIFICATION AND LIMITATION OF LIABILITY

Neither party shall be liable for any dela y or failure in perform ance beyond its control resulting from acts of God or force majeure. The parties shall use reasonable efforts to eliminate or minimize the effect of such events upon performance of their respective duties under Contract.

Contractor shall be fully li able for the actions of its agents, employees, partners or subContractors and shall fully indem nify and save harmless the State and DOH fro m suits, actions, damages and costs of every nam e and description relating to personal injury and dam age to real or personal tangible property caused by Contractor, its agents, em ployees, partners or subContractors, without limitation; provided however, that the Cont ractor shall not indem nify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the State.

Contractor shall indemnify, defend and hold the State harmless, without limitation, from and against any and all damages, expenses (including reasonable attorneys' fees), claims, judgments, liabilities and cost which may be finally assessed against the State in any action for infringement of a United States Letter Patent w ith respect to the Products furnished, or of any copyright, trademark, trade secret or other third party proprietary right in relation to the Products furnished or utilized, provided that the State shall give Contractor: (i) prompt written notice of any action, claim or threat of infringement suit, or other suit, (ii) the opportunity to take over, settle or defend such action, claim or suit at Contractor's sole expense, a nd (iii) assistance in the defense of any such action at the expense of Contractor. Where a dispute of claim arises relative to a real or anticipated infringement, the State may require Contractor, at it's sole expense, to submit such information and docum entation, including formal patent attorn ey opinions, as the Commissioner shall require.

The Contractor shall not be oblig ated to indemnify that portion of dam ages, expenses (including reasonable attorneys' fees), claim s, judgment, liabilities, cost or other dispute based upon: i) DOH unauthorized modification or alteration of a Product; ii) DOH unauthorized use of the Product in com bination with other pr oducts not furnished by Contractor; iii) DOH unauthorized use in other than the specified operating conditions and environment.

In addition to the foregoing, if the use of any item(s) or part(s) thereof shall be enjoined for any reason or if Contractor believ es that it m ay be enjoined, Cont ractor shall have the obligation, at its own expense and sole discretion as the State's exclusive remedy to tak e action in the following order of precedence: (i) to procure for the State the right to continue using such item(s) or part(s) thereof, as ap plicable; (ii) to m odify the com ponent so that it becom es non-infringing equipment of at least equal quality and perform ance; or (iii) to rep lace said ite m(s) or part(s) thereof, as applicable, with non-infringing com ponents of at least equal quali ty and performance, or (iv) if none of the foregoi ng is commercially reasonable, then provide monetary compensation to the State up to the dollar amount of the Contra ct Award. Time is of the essence in matters where the uses of any item(s) or part(s) thereof are enjoined.

For all other claims against the Contractor where liability is not otherwise set forth in the Contract as being "without Limitation," and regardless of the basis on which the claim is made, Contractor's liability under the Contract for direct damages shall be the greater of the following: (i) $1,000,000.00 (ii) the dollar amount of the Contract, or (iii) two (2) times the charges rendered by the Contractor under the Contract and including any amendments. Unless otherwise specifically enumerated herein, neither party shall be liable to the other for special, indirect or consequential damages, including lost data or records (unless the Contractor is required to back-up the data or records as part of the work plan), even if the party has been advised of the possibility of such damages. Neither party shall be liable for lost profits, lost revenue or lost institutional operating savings.

Notwithstanding the foregoing or anything herein to the contrary, the State will not consider any limitation of liability for personal injury or death, infringement, or damage to real or personal property, regardless of the nature of the damages sought for any such claim.

The State may, in addition to other remedies available to them at law or equity and upon notice to the Contractor, retain such monies from amounts due Contractor, or may proceed against the performance and payment bond, maintenance or demolition bond, or letter of credit, if any, as may be necessary to satisfy any claim for damages, penalties, costs and the like asserted by or against them.

The State does not agree to any indemnification provisions that require the State to indemnify or save harmless Contractor or third parties.

2 TERMINATION

1. For Convenience

The State retains the right to cancel the Contract without reason, provided that Contractor is given at least thirty (30) calendar days notice of the State's intent to cancel. This provision should not be understood as waiving the State's right to terminate the Contract for cause or stop work immediately for unsatisfactorily work, but is supplementary to that provision. In the event of cancellation without cause by the State, the State agrees to negotiate a payment based on time, materials and other documented expenses directly attributable to the Contract actually expended by Contractor.

2. For Cause

For any material breach or failure of performance of the Contract by the Contractor, the State may provide written notice of such breach or failure. The State may terminate the Contract if the Contractor does not cure such breach or failure within thirty (30) calendar days after the giving of written notice to cure.

If the Contractor ceases conducting business in the normal course, becomes insolvent, makes a general assignment for the benefit of creditors, suffers or permits the appointment of a receiver for its business or assets or avails itself of or becomes subject to any proceeding under the Federal Bankruptcy Act or any statute of any State relating to insolvency or the protection of rights of creditors, the State, in its sole discretion, may

terminate the Contact in accordance with the Contract or exercise such other remedies as shall be available under the Contract, at law and/or equity.

No delay or omission to exercise any right, power or remedy accruing to the State or DOH upon breach or default by the Contractor under this Contract shall impair any such right, power or remedy, or shall be construed as a waiver of any such breach or default, or any similar breach or default thereafter occurring nor shall any waiver of a single breach or default be deemed a waiver of any subsequent breach or default. All waivers must be in writing.

628) Q: Would the Department agree that neither party will be liable for special, indirect, incidental, consequential, punitive, or exemplary damages (including loss of profits, loss of revenue, or loss of good will) for any claim, whether based on warranty, contract, tort (including negligence), strict liability, or otherwise, even if the party has been advised of the possibility of such damages?

Answer: Yes, please see above response.

629) Q: Would the Department agree that Contractor may terminate for cause after providing the Department with 30 days' notice of default and an opportunity to cure?

Answer: No.

630) Q: Would the Department be willing to provide Contractor with the right to terminate the contract without cause during the contract, understanding that such a provision may be in the best interests of the Contractor and the Department, if unforeseeable circumstances make a termination desirable for the Contractor and the Department?

Answer: No.

631) Q: Would the Department agree to excuse performance or a delay in performance by the Contractor as a result of any event beyond the reasonable control of Contractor, including but not limited to strikes, telecommunications outages, and terrorist acts, so long a performance is excused only to such extent and duration as is reasonably necessary?
Q: Will NYS DOH include a force majeure provision in the contract that acknowledges the existence of events outside of the reasonable control of either party which may impact performance, and identifies that neither party should be liable?

Answer: Refer to the following force majeure language:

1. A force majeure occurrence is an event or effect that cannot be reasonably anticipated or controlled by the State or the Contractor, its subContractors, or others under the Contractors or its subContractor's control. Force majeure includes, but is not limited to, acts of God, acts of war, acts of public enemies, strikes, fires , explosions, actions of the elements, floods, or other similar causes beyond the control of the Contractor or the Department in the performance of the Contract which non-performance, by exercise of reasonable diligence, cannot be prevented,. The Contractor shall provide the Department with written notice of any force majeure occurrence as soon as the delay is known.

2. Neither the Contractor nor the Department shall be liable to the other for any delay in or failure of performance under the Contract due to a force majeure occurrence. Any such delay in or failure of performance shall not constitute default or give rise to any liability for damages. The existence of such causes of such delay or failure shall extend the period for performance to such extent as determined by the Contractor and the Department to be necessary to enable complete performance by the Contractor if reasonable diligence is exercised after the cause of delay or failure has been removed.

3. Notwithstanding the above, at the discretion of the Department where the delay or failure will significantly impair the value of the Contract to the Department, the Department may:

a. Accept allocated performance or deliveries from the Contractor. The Contractor, however, hereby agrees to grant preferential treatment to the Department with respect to product, materials, or services; and/or

b. Purchase from other sources (without recourse to and by the Contractor for the costs and expenses thereof) to replace all or part of the product, materials, or services which are the subject of the delay, which purchases may be deducted from the Contract quantities without penalty or liability to the Department; or

c. Terminate the Contract or the portion thereof which is subject to delays, and thereby discharge any unexecuted portion of the Contract or the relevant part thereof.

4. In addition, the Department reserves the right, at its sole discretion, to make an equitable adjustment in the Contract terms and/or pricing should extreme and unforeseen volatility in the marketplace affect pricing or the availability of supply. "Extreme and unforeseen volatility in the marketplace" is defined as market circumstances which meet the following criteria: (i) the volatility is due to causes outside the control of the Contractor; (ii) the volatility affects the marketplace or industry, not just the particular source of supply utilized for performance of this Contract; (iii) the effect on pricing or availability of supply is substantial; and (iv) the volatility so affects the Contractor's performance the continued performance of the Contract would result in substantial loss.

632) Q: Please tell us of any liquidated damage and assessed penalties that any of the current vendors paid during any part of their contract.

Answer: None.

633) Q: Please confirm that no liquidated damages will be assessed with respect to Contractor performance on this Agreement.

Answer: As stated in the eighth paragraph of Response number 627: "Notwithstanding the foregoing or anything herein to the contrary, the State will not consider any limitation of liability for personal injury or death, infringement, or damage to real or personal property, regardless of the nature of the damages sought for any such claim."

634) Q: We acknowledge and will agree to a HIPAA Business Associate Agreement if awarded this work; however for confidentiality reasons we request that DOH agree to a change in section

II(h) that disclosure of our internal policies, books and records be limited to the Secretary of Health and Human Services.

Answer: No.

635) Q: How is the notice of privacy practices currently distributed to program applicants? For the web site renewal web pages, can the Department provide a link for program participants to view the current notice of privacy practices?

Answer: The current notice of privacy practices is mailed to program applicants. It is also available for viewing on the DOH website at **http://www.health.ny.gov/health_care/medicaid/publications/docs/inf/06inf-03att1.pdf** . Once the contract is awarded, the Department will work with the Contractor on developing an electronic system for this notice, which meets the requirements of the HIPAA regulations.

636) Q: Since neither party will necessarily know in advance what might be required to comply with future regulatory changes, we request that the following italicized text: "The Parties agree to *work together in good faith* to take such action as is necessary" be added.

Answer: No.

637) Q: Is the Department amenable to having the Contractor provision a private circuit into the state data center and install a router/firewall to terminate this circuit in order to facilitate the connectivity necessary to meet RFP requirements? If yes, is there one state data center where a circuit can be terminated that would allow connectivity to all state systems, or will multiple circuits be required?

Answer: Specific information and data needs of the Contractor may be addressed when the contract is awarded.

638) Q: According to the Procurement Schedule, responses to bidders' questions are not due until January 15th. Responses to these questions are critical to the development of responsive technical and cost proposals for all bidders. The schedule as it is provides limited time (i.e., less than a month) for bidders to modify/adjust their cost and technical proposals to reflect necessary changes that result from the Department's responses. Will the Department consider providing responses to questions at an earlier date (i.e., December 15th)? If this is not possible, would the Department consider extending the proposal due date by 30 days to allow bidders sufficient time to prepare the most innovative and quality proposals?

Answer: The due date for receipt of proposals has been extended to March 19, 2009. This provides the necessary time for the Department to complete the second set of questions and answers and for bidders to have the information necessary to prepare their response.

639) Q: RFP states that FHP materials be written at the fourth grade reading level (page 30). In the Premium Assistance Program section of the RFP it states that materials be written at the fourth to sixth grade reading level (page 26).
Q: Did the State intend to have different reading level standards for the different types of materials?

Answer: No. All materials should be prepared at the fourth grade reading level.

640) Q: Will the Contractor be responsible for making referrals to Protective Services if they become aware of situations that would warrant such a referral?

Answer: No.

641) Q: Would the Government be open to alternate technical implementations?

Answer: No. The RFP does not allow for alternate technical implementations.

642) Q: Can we get sample reports from current systems?

Answer: No.

643) Q: The RFP notes a 30 day cancellation clause by the Government. It is noted that the selected Contractor may have significant staff. Would this cancellation only be applicable in terms of breach? Would the Government consider a longer period to protect the staff?

Answer: Response: No, this termination would not be applicable only in terms of breach and the State would not consider a longer period.

644) Q: How will the Department reconcile if there are differences between county and Department interpretations?

Answer: The Contractor will follow the policies and procedures set forth by the State.

645) Q: Will the Department under any circumstances award a contract to a bidder for only some of the required services, and select more than one bidder?

Answer: No. The Department will not select more than one bidder.

646) Q: What are the requirements and frequency for Departmental audits?

Answer: This is at the Department's discretion.

647) Q: How would the selected bidder handle complaints concerning their performance? Is there a State contact that members could call?

Answer: Yes, that contact will be provided to the Contractor.

648) Q: Will the State share policy and procedure manuals, process descriptions, work flows, and other similar materials?

Answer: Yes, subsequent to the contract approval, the state will share the applicable information with the Contractor.

649) Q: Could the Department please provide the names of vendors currently involved with individual projects within the scope of work set forth in the RFP, and describe the specific nature of the work performed by each vendor?

Answer: This project is a new initiative. Vendor names have been provided where relevant. The RFP provides the information bidders need to prepare and present their proposals.

650) Q: Is it possible for the Department to provide current vendor fees, and what the average monthly volume is during the past 12 months?

Answer: The volume information is provided in the RFP and these answers. The vast majority of these services are not being provided by vendors at this time.

651) Q: Would the Department please provide the number of staff used by the current vendors for each of their respective projects.

Answer: We have provided the available information earlier in this document and in the first Q and A.

652) Q: Please tell us of any liquidated damage and assessed penalties that any of the current vendors paid during any part of their contract.

Answer: None

653) Q: In submitting the proposal, can the winning Contractor assume the State contemplates a negotiation process upon award during which the parties may agree to modified or additional terms to the Contract?

Answer: Pursuant to paragraph F(4) of Part VIII of the RFP, the Department reserves the right to negotiate with vendors responding to the RFP within the requirements of the RFP to serve the best interests of the State.

Attachments

654) Q: Line Item A under Attachment A Bid Form reads: "Name of Offerer/Bidder bids a total price of $____". Should this Total Price be for 1-, 2-, 5-, or 7-year duration?
Q: Can you offer guidance on how the Total Price should be calculated, especially since the price submitted on Cost Worksheets (Attachment J) are for different bands?
Q: On Attachment A Bid Form the bidder must include the "Total Bid Price". Please indicate how this should be determined given that pricing is tiered for different volumes.

Answer: The Total Bid Price on the Bid Form (Attachment A) should state "see Attachment J" (Cost Worksheets).

655) Q: Would the Department agree that if rules, policies, procedures, guidelines or changes in regulations in laws affect the cost of providing the services, the Department shall make an equitable adjustment in compensation?

Answer: To the extent that such a mandate would not change the scope of services contemplated in the RFP the Department would not agree to make such an adjustment.

656) Q: Would the Department clarify that the Contractor retains ownership of (i) work developed prior to the effective date of the contract and without federal funds, (ii) general know-how, and (iii) proprietary standard operating procedures? Department ownership of work acquired or created by Contractor before the contract does not provide Department with any significant benefit and discourages the innovation that Department is seeking in proposals resulting from the RFP.

Answer: Yes, the prohibitions contained in Appendix D apply only to information developed under or in the course of performing the resulting contract, it does not apply to work developed prior to the effective date, general know how, or to the Contractor's general operating procedures.

657) Q: Given that there are no dates identified on page one of the BAA please confirm that the Term of the BAA as the dates of performance under a resultant contract award, estimated as September 26, 2008 through September 25, 2009 as provided on the Position Recruitment Forms.

Answer: See RFP page 64, section K and appendix H, Miscellaneous section C. Also, bidders should be aware that HIPAA regulations remain after term of contract.

658) Q: Please confirm that the reference to "Master Agreement" of the Agreement means the contract issued to support Project Definition DOH 2008-14.

Answer: "Master Agreement" means the resulting contract from an award from this RFP.

659) Q: Please confirm that the indemnification applies to the extent required by the HIPAA regulations; and that therefore it is correct to interpret the indemnification as covering the cost of penalties assessed by the Secretary of Department of Health and Human Services or the State (including the State's reasonable attorneys' fees) pursuant to the applicable HIPAA regulations. In addition, the State will promptly notify the Contractor of any claim or action covered under this provision, with the Contractor controlling the defense and settlement of such claim.

Answer: Yes, agreed.

660) Q: How is the notice of privacy practices currently distributed to program applicants? For the web site renewal web pages, can the Department provide a link for program participants to view the current notice of privacy practices?

Answer: The current notice of privacy practices is mailed to program applicants. It is also available for viewing on the DOH website at **http://www.health.ny.gov/health_care/medicaid/publications/docs/inf/06inf-03att1.pdf** . Once the contract is awarded, the Department will work with the Contractor on developing an electronic system for this notice, which meets the requirements of the HIPAA regulations.

661) Q: Please indicate if HIV/AIDS information is to be disclosed to Contractor during the project.

Answer: If HIV/AIDS information is provided on the health assessment form, the EC may have this information. At this time, we have not determined if this will be an EC responsibility.

662) Q: Will NYS DOH agree that changes outside the scope of the RFP would be addressed through a mutually agreed upon change request process and that depending on the scope and nature of such changes, additional fees may apply?

Answer: No.

663) Q: Will NYS DOH include a warranties provision based on an objective industry-standard for performance, and a disclaimer of other warranties not expressly provided for in the agreement including but not limited to standard implied warranty limitation language excluding implied warranties of merchantability and fitness for a particular purpose?

Answer: The Department feels that the detailed project specifications contained in the RFP serve as all required warranties for purposes of this agreement.

664) Q: Because per page prices for development and printing of outreach materials and applications will be reduced as volumes increase, is it acceptable to annotate this cost form for costs proposed at various printing volume levels?

Answer: No the cost forms in Attachment J cannot be annotated, any such costs should be included in the unit price bid.

665) Q: The Bid Forms (Attachment J) requires three tiers of volume related bids with current & expected volumes at the first tier levels. Does the State believe that the current & expected volumes will change significantly up or down over the contract period?

Answer: The state cannot predict or guarantee how volumes will change over the contract period. Since this is the development of a new and innovative service in New York State, we are only able to guess that the volumes will be within the ranges we provided.

666) Q: Can start-up costs be proposed as a part of the Development of Program Materials?

Answer: See RFP p. 51.