



# Department of Health

## Request for Proposals

**RFP # C040633**

## Enrollment Broker Services

**Issued: February 13, 2025**

### **DESIGNATED CONTACT:**

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

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### **PERMISSIBLE SUBJECT MATTER CONTACT:**

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

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## 1.0 CALENDAR OF EVENTS

<b>RFP C040633 – ENROLLMENT BROKER SERVICES</b>	
<b><u>EVENT</u></b>	<b><u>DATE</u></b>
Issuance of Request for Proposals	February 13, 2025
Deadline for Submission of Written Questions	Questions Due By February 27, 2025 at <b>4:00 p.m. ET</b>
Responses to Written Questions Posted by The Department	Responses Posted on or about March 18, 2025
Deadline for Submission of Proposals	Proposals Due On Or Before April 11, 2025 at <b>4:00 p.m. ET</b>
<u>Anticipated</u> Contract Start Date	April 1, 2026

## 2.0 OVERVIEW

Through this Request for Proposals (“RFP”), the New York State (“State”) Department of Health (the “Department” or “DOH”) is seeking competitive proposals from qualified bidders to provide education/outreach, enrollment, and evaluation/assessment services as further detailed in [Section 4.0](#) (Scope of Work). It is the Department’s intent to award one (1) contract from this procurement.

### 2.1 Introductory Background

#### A. Introduction

The single state Medicaid agency for New York is the State Department of Health. Many of the functions of the Medicaid program in New York are currently conducted on behalf of the Department by Local Departments of Social Services (LDSS) in each borough/county of the State. The LDSS in New York City is the Human Resources Administration (HRA). The Developmentally Disabled Regional Offices (DDRO), the Office of Mental Health (OMH), the Office of Addiction Services and Supports (OASAS), and the New York State of Health insurance exchange (NYSoH) may also be considered LDSS.

The New York State of Health (NYSoH) is the health insurance exchange or marketplace for the State of New York established in 2013 under the Affordable Care Act, where consumers may apply for Medicaid and enroll in a Medicaid Managed Care plan. NYSoH may also act as a separate LDSS.

Currently, NYSoH establishes and recertifies Medicaid eligibility for individuals, processes various enrollment transactions, and transmits that information to the electronic Medicaid New York (eMedNY) system. LDSS staff also establish and recertify Medicaid eligibility for individuals and provide that information to the State via the State’s Welfare Management System (WMS) legacy system, which is being phased out over the long term. Both NYSoH and WMS transactions are currently housed in eMedNY. The enrollment broker has no role in establishing Medicaid eligibility, and Medicaid eligibility questions from consumers are referred to the LDSS. In June 2011, the State also established a Statewide Enrollment Center to consolidate customer service helplines for Medicaid and Child Health Plus (CHPlus), and to process telephone renewals.

The Department's Office of Health Insurance Programs (OHIP), Division of Health Plan Contracting and Oversight (DHPCO), in collaboration with its LDSS partners, is responsible for day-to-day oversight of the managed care program described in the RFP.

## **B. Program Backgrounds**

New York State currently operates several managed care programs, which are listed below, and may expand managed care to additional programs in the future.

- Medicaid Managed Care (MMC) Program
- HIV Special Needs Plans (SNP)
- Health and Recovery Plans (HARP)
- Managed Long Term Care (MLTC)
  - Managed Long-Term Care Partially Capitated Plans (MLTCP)
  - Medicaid Advantage Plus (MAP)
  - Program of All-Inclusive Care for the Elderly (PACE) Organizations
  - Fully Integrated Duals Advantage – Intellectual and Developmental Disabilities (FIDA-IDD) Plans

***Descriptions of these programs are provided in Attachment D.***

## **2.2 Important Information**

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

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

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

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

## **2.3 Term of the Agreement**

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

Comptroller (OSC). It is anticipated that the contract resulting from this RFP is anticipated to begin on April 1<sup>st</sup>, 2026 for either the incumbent contractor or a new contractor. It is anticipated that if a new contractor is awarded, they will be afforded a six (6) month transition period to ramp up its services.

The pricing for years four (4) and five (5) of the Contract is subject to an annual increase or decrease as described in [Section 4.14](#) Payment.

### **3.0 BIDDERS' QUALIFICATIONS TO PROPOSE**

#### **3.1 Minimum Qualifications**

The NYSDOH will accept proposals from bidders with the following types and levels of experience as a prime contractor.

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

- Bidder must have at least 5 years' experience with:
  - Performing Enrollment Broker services for a Medicaid program with at least 500,000 beneficiaries;
  - Providing Call Center support for health plan choice counseling and enrollment broker services for Medicaid population of at least 500,000;
  - Performing Medicaid Enrollment activities for potential beneficiaries;
  - Performing Managed Care Enrollment activities for a population of at least 1,000,000;
  - Providing Managed Care Education in person, by phone and by mail;
  - Performing or managing Large Scale Mailing Projects of at least 50,000 mailings; and
  - Operating a consumer-facing customer service center/call center that handles high volumes (at least 15,000 calls per day) of telephone calls.

Experience acquired concurrently is considered acceptable.

For the purposes of this RFP, a "prime contractor" is defined as one who has the contract with the owner of a project or job and has full responsibility for its completion. A prime contractor undertakes to perform a complete contract and may employ (and manage) one or more subcontractors to carry out specific parts of the contract.

### **4.0 SCOPE OF WORK**

This Section describes the enrollment and education/outreach services in support of New York State's Medicaid program and Care Management for All initiative that are required to be provided by the selected bidder. The selected bidder must be able to provide all of these services throughout the contract term.

The Department is seeking a Contractor to perform enrollment, education, outreach, evaluation/assessment, plan of care development, and monitoring access to services in support of New York State's Medicaid program and Care Management for All initiative.

The issuance of this RFP and the subsequent contract award is intended to meet several objectives. The successful bidder will be expected to:

- Educate Medicaid applicants/recipients and consumers, providers, and other interested parties in the community regarding:
  - Medicaid Managed Care plans;
  - Special Needs Plans (SNP);
  - Health and Recovery Plans (HARP);

- o Medicare-Medicaid dual-eligible plan (Medicaid Advantage Plus);
  - o Managed Long Term Care Partially Capitated Plans;
  - o Programs of All-Inclusive Care for the Elderly (PACE);
  - o Fully Integrated Duals Advantage for intellectually and developmentally disabled (FIDA-IDD); and
  - o Any other new managed care program in New York State established during the term of the resulting contract;
- Educate potential enrollees about managed care concepts, their enrollment options, and provide assistance with health plan selections and Medicaid recertifications;
  - Process managed care enrollment exemption and exclusion requests for Medicaid recipients;
  - Process enrollments and disenrollments for all managed care programs;
  - Assist enrollees with Primary Care Provider (PCP) selection, as requested by enrollees;
  - Provide an efficient and cost-effective enrollment process; and
  - Provide an effective data reporting system regarding enrollments, disenrollments, exemptions, transfers, outreach and education activities and complaints and grievances.

**PLEASE NOTE:** Bidders will be requested to provide responses that address all of the requirements of this RFP as part of its Technical Proposal, including flexibility for expansion to support the requirements of the Department, and in response to changing State and Federal regulations (See Section 6.2).

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

#### **4.1 Tasks/Deliverables**

Through the resulting contract, the Enrollment Broker (Contractor) will be responsible for performing enrollment, outreach and education services leading to the maximized enrollment of the targeted populations into managed care.

The Contractor will develop an approach and implement activities to educate and enroll eligible consumers into managed care plans, and provide continued assistance to enrolled members, such as managing complaints, processing transfers and providing assistance with Medicaid recertifications. Although the Contractor will primarily operate in a mandatory environment, the approach must be flexible to accommodate the Department’s needs under both a voluntary and mandatory program in any county of the State, and to reflect specific program requirements, enrollment policies and procedures.

The Contractor must provide the following core services:

1. Enrollment/Disenrollment Activities
2. Mailings
3. Outreach and Education Activities
4. Program Materials
5. HelpLine
6. Fair Hearing Responsibilities
7. Development and Implementation of an Internal Quality Assurance Program

Each of these functions and other key services are described in further detail below.

#### **4.2 Enrollment/Disenrollment Activities**

The Contractor shall be responsible for enrolling individuals in appropriate health care plans as specified by the Department. The Contractor must provide and manage staff, and develop, document, and maintain computer systems necessary to carry out all enrollment functions described in this section. The State has several models of enrollment, including mandatory with auto assignment, passive with opt out, and voluntary.

The Contractor must contact and inform individuals to be enrolled in managed care about the program options and health plans available. The primary goal is to permit as many people as possible to make health plan selections, thus minimizing the number of automatic assignments of consumers to health plans. Medicaid consumers who are enrolled at the time their benefits are reauthorized do not have to “reenroll” in or select a managed care plan; they will remain enrolled in the current managed care plan.

The Contractor must conduct outreach, education, and enrollment activities as appropriate, and is responsible for the development of consumer materials, brochures, notices, telephone scripts, and other communications as further defined below.

For the FIDA-IDD product, the Contractor must coordinate enrollment activity with the Federal interface to confirm/enroll, and to disenroll consumers in receipt of Medicare from the FIDA-IDD product or transfer to other appropriate product.

#### ***4.2.1 Enrollment Application Processing***

The Contractor shall process hardcopy enrollment applications within three (3) business days. Electronic enrollment files must be processed within one (1) business day of the posting of those enrollment files by the plans. “Process” shall mean the initial evaluation of the application for enrollment, either manually or via the data system, for completeness and accuracy in comparison to the eligibility data provided by the Department, or other information available to the Contractor such as exemption/exclusion status or pending enrollment in another plan. The Contractor must take action to continue the enrollment process, such as: prepare denial information, process to completion and enrollment, or any other appropriate action based on the information provided and the consumer’s eligibility status. Enrollment requests must then be either submitted to the State data system for enrollment, returned to the consumer for additional information, or denied based on program criteria, such as lack of Medicaid eligibility or exclusion from Medicaid managed care enrollment.

The Contractor must be able to identify possible duplicate enrollments based on the Department’s criteria and prevent multiple enrollments.

Certified Application Counselors and community based organization (CBO) enrollers may submit enrollment requests. These enrollments must not be denied for a lack of eligibility, but rather pended until the Medicaid eligibility is established and sent to the Contractor via the daily update of Medicaid eligibility. The Contractor electronically matches the new eligibility with the pended managed care choice and processes the enrollment to completion, including sending the confirmation notice. LDSS eligibility workers are also able to enroll new Medicaid cases. In NYC, this is referred to as the “one-step” enrollment process. In those cases, the Contractor receives the enrollment electronically from HRA and sends the enrollment confirmation notice. Similarly, HRA workers may also enter the managed care choice for Medicaid cases that apply directly at HRA offices.

All consumers who are determined financially eligible for Medicaid and have not chosen a health plan must be offered the opportunity to select a plan for enrollment by telephone. Consumers who are required to enroll in a managed care plan and who enroll by telephone, must be sent a packet containing a phone enrollment confirmation notice that includes the name of the plan selected. Consumers are asked to review the form upon receipt, sign it, and return it to the enrollment broker. The receipt is noted in the data system, the original is stored by the Contractor, and a copy is provided to the health plan chosen. Telephone enrollments must be processed regardless of whether the consumer returns the enrollment form.

Incomplete enrollment forms shall be reconciled with the individual requesting enrollment, with instructions for completing the missing information. Returned health assessment forms must be collected within three (3) business days of receipt, and forwarded to the appropriate managed care plan.

Currently, the State is responsible for producing a monthly enrollment roster for each managed care plan and district. The rosters are effective the first of a calendar month. The cutoff, or "pulldown", for enrollments to appear on the State roster is 7-10 days prior to the first of the roster month for enrollments other than the dually eligible population, in which case, enrollments must be allowed through the end of the month. Hardcopy enrollment applications received by the Contractor up until three (3) days before the State enrollment pulldown date, must be processed for an effective date of the following month. Electronic and phone enrollments that are submitted up until one business day before the pulldown, must also be effective for the following month. However, in the interest of enrolling eligible consumers into the health plan of their choice as soon as possible, the Contractor shall make efforts to revise processing procedures and/or staffing such that the maximum number of enrollments received before pulldown are effective the following month, even those submitted closer to the pulldown than the timeframes stated above. The Contractor must notify the plan in writing or electronically, of the enrollments that occur after the primary pulldown.

A confirmation notice mailed within three business days that contains the names of the enrolled consumers, the effective date of enrollment, the name of the plan in which they have enrolled, and information about lock-in and transfer, must be sent to each household enrolled through the Contractor.

#### ***4.2.2 Determination of Eligible Individuals/Exemption and Exclusion Process***

The Department or its designee will perform all determinations of Medicaid financial eligibility. The Contractor and the Department, or its designee, will coordinate to ensure that the Contractor possesses a current listing of potential enrollees. This function will be accomplished electronically on a daily basis. The Department will attempt to identify as many of the excluded and exempt individuals as possible through eligibility and claims data. However, the Contractor will also be expected to work with individuals who may be exempt or excluded from mandatory enrollment and assist individuals in applying for exemption or exclusion status.

Due to the complex nature of some exempt beneficiaries' situations, the Contractor must be able to work with beneficiaries who express a desire to apply for an exemption using one or more criteria for non-participation in the managed care program or mandatory enrollment. Since some individuals with Medicaid eligibility have circumstances that may provide more than one reason for exemption or exclusion from mandatory managed care enrollment, the Contractor's staff must be able to discuss the exemption and exclusion criteria with callers and identify the one or more categories, including waiver programs, for which the consumer may apply. This case management approach should assist the consumer in obtaining the most favorable type of exemption or exclusion, or waiver program enrollment. In addition, this case management approach must be used in other situations where a thorough discussion with the consumer is required to fully explain the details of the managed care program and the options available given a person's circumstances, such as callers interested in learning about the HIV Special Needs Plans, Health and Recovery Plans or Managed Long Term Care options.

All consumer requests for exemptions and exclusions will be in writing and directed to the Contractor. Within three (3) business days, the Contractor must review all requests, and if incomplete, contact enrollees or providers to obtain missing information. Recommendations for denials will be forwarded to the Department, or its designee, for final decisions. Once a determination has been made, the Contractor must notify enrollees in writing that the exemption or exclusion has been granted or denied.

Any disenrollments that result from approval of an exemption or exclusion request will be processed prospectively following the Medicaid pull down schedule, unless the enrollee is eligible for an expedited or retroactive disenrollment. The disenrollment must be effective the first of the following month, if

allowed by the enrollment pull down schedule, but may not be any later than the first of the second month.

In addition to identifying potentially excluded/exempt populations and processing exemption/exclusion applications, the Contractor must develop a managed care eligibility database that is compatible with the Department's systems specifications. The Contractor's data system must be capable of tracking exemption and exclusion requests and decisions and preventing further actions from taking place on those beneficiaries, such as routine mailings requiring enrollment or auto assignment to a plan. The Contractor's data system must be able to pass the file of identified exemptions/exclusions that are granted or ended to the State system for local districts to view this information. The Contractor's system must also be able to process ad hoc disenrollments per State guidelines for those who are deemed excluded from managed care enrollment.

#### **4.2.3 Auto-Assignment**

The Contractor shall assign a health plan to a Medicaid consumer who does not enroll in or choose a Medicaid Managed Care plan at the time of new application or within sixty (60) days of receipt of the mandatory notice, and for current Medicaid recipients that do not choose a plan after the initial and only mailing. For Managed Long Term Care enrollment, the contractor must allow eligible recipients sixty (60) days to select a plan before assigning a MLTC plan.

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

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

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

#### **4.2.4 Health Assessment Forms**

The Contractor must assist the LDSS or managed care plan in identifying any existing medical (e.g., pregnancy or chronic illness) or behavioral condition requiring immediate follow-up by the plan upon enrollment as appropriate. This information will be collected in a health assessment form developed by the Department, and maintained by the Contractor. In counties where the Contractor provides enrollment broker services, the Contractor collects health assessment information during the initial enrollment call and electronically transmits the data to the health plan with the daily enrollment file. If the health assessment is not completed electronically, the Contractor shall include the Health Assessment Form with the enrollment confirmation notice, with a business reply envelope.

Medical information collected by the Contractor by virtue of the health assessment form shall not be considered or discussed with the individual as it may relate to selection of a health plan. The instrument shall be completed after the individual has selected a plan. The Contractor must develop and monitor controls to assure confidentiality of all information collected. All such inquiries into a person's health status may only occur after an enrollment choice has been made. Completed health assessment forms that are returned or given to the Contractor must be forwarded to the health plan selected by the consumer.

#### **4.2.5 Post Enrollment Surveys**

The Contractor will be expected to conduct a post-enrollment survey of consumers assisted through enrollment processes excluding the process conducted by the Contractor to evaluate whether they were given information on the managed care plan options. The survey is conducted by phone on a quarterly basis with a minimum of 150 completed surveys each quarter.

#### **4.2.6 Health Plan Changes**

Medicaid managed care enrollees may change health plans for any reason during the first 90 days of enrollment (grace period). After the grace period, the consumer must remain enrolled for the next 9 months (lock-in) unless a good cause reason for disenrollment is established and approved by the Department. Persons with HIV infection or AIDS whose local district of residence qualifies them for enrollment in a HIV SNP are not subject to lock-in, and may request transfer from a Managed Care Organization (MCO) to an HIV SNP, or from HIV SNP to another HIV SNP, at any time. The Contractor will be responsible for assisting enrollees that elect to change plans within the grace period, after the lock-in period ends, and within the lock-in period with good cause for consumers subject to lock-in rules.

Individuals who have good cause to disenroll because they are in an exempt or excluded category may transfer to another plan. Disenrollment to fee for service Medicaid must be minimized by the Contractor whenever possible for populations required to enroll in Medicaid Managed Care and Managed Long Term Care.

New York State offers no managed care guarantee coverage. Loss of Medicaid eligibility will cause plan enrollment to be truncated. The Contractor will also be responsible for processing these transactions.

The Contractor will be expected to track the lock-in period and send an end of lock-in notice within State mandated timeframes. The Contractor will also be expected to assist in the transition of enrollees to other health plans when the Department determines that a significant change at the managed care plans, such as large-scale network changes, plans terminating their contract to provide Medicaid managed care, or changes in health plan ownership makes such transfer appropriate. The tasks for the Contractor for such transitions include but are not limited to: sending enrollment notifications, managing the resulting transfers or disenrollments, responding to phone inquiries regarding the change, and providing enrollment activity summary reports to the Department and/or local district. The Contractor sends out all appropriate enrollment notices, including change, enrollment, and/or disenrollment notices.

Disenrollments are processed prospectively to be effective the first of the next month, following the Medicaid pull down schedule, unless the enrollee is eligible for an expedited or retroactive disenrollment. Retroactive disenrollments are rare.

#### **4.2.7 Program-specific Enrollment Activities**

##### **4.2.7.A HIV Special Needs Plans (SNP)**

With regard to HIV Special Needs Plans, the Contractor shall provide regional/virtual trainings to all education and enrollment counselors in the differences between Special Needs Plans and the other managed care plans. The Contractor must also provide regional/virtual trainings to all enrollment

counselors in confidentiality issues specific to Persons Living with HIV/AIDS. In addition, the Contractor must ensure that the data systems can accommodate enrollment to, and disenrollment from, the Special Needs Plans.

The Contractor must accept enrollment applications for Special Needs Plans and process such enrollments within one business day when submitted by the Special Needs Plan via electronic files.

If a consumer requests enrollment materials for enrollment into a Special Needs Plan, and further requests that the enrollment package be sent to an alternative address, the Contractor must honor that request and mail the packet within three days. All subsequent correspondence shall be sent to the address of record in the Medicaid data system that is provided to the Contractor. In addition, consumers may request their phone number will not be used for follow-up calls related to the Special Needs Plan. The Contractor must also be able to accommodate a person's request not to receive telephone calls from the Contractor related to HIV Special Needs Plan enrollment, such as follow up on applications, etc.

The Contractor conducts outreach about the Special Needs Plans at designated LDSS sites, including group and/or one-on-one presentations. The Contractor must provide assistance to those consumers who express interest in the Special Needs Plans, including general assistance with enrollment or transfers, and connecting the consumer to the health plan of choice.

#### **4.2.7.B Health and Recovery Plans (HARP)**

With regard to Health and Recovery Plans, the Contractor shall provide regional/virtual trainings to all education and enrollment counselors in the differences between HARPs and the other managed care plans. In addition, the Contractor must ensure that the data systems can accommodate enrollment to, and disenrollment from, the Health and Recovery Plans. The Contractor will provide assistance to those consumers expressing interest in the Health and Recovery Plans, including general assistance with enrollment or transfers, identifying plan-provider affiliations, and connecting the consumer to the health plan of choice.

For the Health and Recovery Plans, the Contractor must conduct enrollment counseling, outreach, and education to consumers established by the Department as eligible for HARP enrollment. Eligibility is currently established through systemic identification based upon service utilization patterns for enrollees in a Medicaid Managed Care plan or HIV Special Needs Plan.

HARPs were established as a separate line of business for existing Managed Care Organizations (MCO). Therefore, only MCOs operating a Medicaid Managed Care plan may operate a HARP currently, although not all MCOs elected to do so. HARP enrollment is either voluntary or passive, based upon the availability of an affiliated HARP product for enrollment. Individuals must be 21 or older and be eligible for Medicaid Managed Care to join a HARP. People must also meet the NYS behavioral health high-risk criteria to enroll in a HARP. Individuals who are eligible will get a letter in the mail from NYS or New York Medicaid Choice notifying them of their eligibility. Consumers identified as HARP eligible and enrolled in a mainstream Medicaid Managed Care plan having an affiliated HARP product available are passively enrolled in the HARP, and may elect to opt out. Those enrolled in a mainstream Medicaid Managed Care plan without an affiliated HARP product must actively elect to enroll in a HARP. Those enrolled in an HIV Special Needs Plan and found to be HARP eligible may remain enrolled in the SNP, and receive through the SNP the same additional benefits available through HARP enrollment. The Contractor must conduct outreach, education, and enrollment activities as appropriate, based upon current plan enrollment, including development of consumer materials, notices, phone scripts, and other communications.

HARP enrollments began October 1, 2015, with individuals residing in New York City and meeting eligibility criteria, as defined by the State, and currently enrolled in a mainstream Medicaid Managed Care plan. The target population will be identified and provided to the Contractor by the Department via the daily eligible file. The Contractor shall provide consumers with unbiased guidance on plan enrollment options, eligibility criteria for HARP enrollment and Behavioral Health Home and Community Based Services, service provider

affiliations, plan options, and enrollment policies and procedures. The estimated number of eligible individuals is approximately 150,000 Statewide. The Contractor shall also ensure staff are educated regarding the differences between HARP, HIV SNP and Medicaid Managed Care enrollment, including covered services, enrollment policies and procedures, and other criteria, such as evaluations and assessments.

#### **4.2.7.C Medicaid Advantage Program (Dually-eligible enrollment)**

The Contractor must work closely with the Medicaid Advantage health plans to ensure timely enrollment into the Medicaid part of the managed care plan, ideally with the same effective date as the Medicare Advantage enrollment processed by the health plan. Medicaid Advantage health plans electronically submit all new enrollments to the Contractor. The Contractor will accept these enrollments up to noon of the last business day of the month. If Medicare information is not on the Contractor or State data systems, the Contractor will collect documentation of Part A and Part B Medicare from the health plan, and forward that documentation to the LDSS so the LDSS can update the eligibility data systems. As long as documentation is available, the enrollment must still be processed despite the lack of Medicare information on the system.

Transfer and disenrollment requests may be received from the consumers or the health plans. Consumers cannot be enrolled in the Medicaid Advantage product without also being enrolled in the same plan's Medicare Advantage product.

The Contractor will send all appropriate enrollment, disenrollment, and transfer notices for Medicaid Advantage transactions to the enrolled individual.

#### **4.2.7.D Managed Long Term Care - Mandatory Managed Long Term Care**

As with mainstream Medicaid Managed Care enrollment, the Contractor will assist in the development, production and distribution of these materials. If the individual does not select a plan for enrollment, he/she will be auto-assigned to a partially capitated plan within 60 days. The Contractor will be responsible for auto assigning these individuals. It is expected that approximately 2,000 cases per month will transition to MLTC or other care coordination models. Enrollees have the ability to disenroll from one plan and join another if dissatisfied. New Medicaid applicants who are also in need of Community Based Long Term Services and Supports (CBLTSS) must be provided with similar information and have choice of the types of plans and programs available.

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

Bidders are expected to include a description of how they would provide support for mandatory MLTC enrollment that mirrors the processes utilized in Medicaid Managed Care enrollment in their proposed approach.

Enrollment in a Managed Long Term Care Plan (MLTCP) will be processed by the enrollment broker through the following process:

- Recipients seeking Personal Care Services and/or Consumer Directed Personal Assistance Program or MLTC plan eligibility are referred to the New York State approved independent assessor for an assessment to determine eligibility. If determined eligible by the independent assessor, the enrollment broker educates recipients on plan options.
- The selected MLTCP reviews the New York State approved assessment tool; develops a Plan

of Care for enrollee, and submits enrollment to the broker.

- Any questions due to incomplete/inconsistent material are sent back to the MLTCP for resolution.
- If enrollment submission is acceptable, the enrollment broker processes transaction to PCP subsystem and sends notice to the enrollee.
- If the MLTCP proposes a denial of enrollment, the enrollment broker must concur with denial; if in agreement, the broker must send a notice of fair hearing to applicant. If the enrollment broker does not concur, it must discuss with the MLTCP. If not resolved between the enrollment broker and MLTCP, this must move to dispute resolution process.
- If the MLTCP proposes to involuntarily disenroll an enrollee, the MLTCP provides the enrollment broker with supporting documentation. The enrollment broker must concur or disagree with disenrollment based on their review. If the enrollment broker concurs, the broker must send disenrollment and fair hearing notices to the enrollee. If the enrollment broker does not concur, it must discuss with the MLTCP. If not resolved between the enrollment broker and MLTCP, this must move to dispute resolution process.
- Managed Long Term Care program enrollments, disenrollments, recertification and transfer requests are submitted to the Contractor by the plan. The Contractor generates all appropriate enrollment, disenrollment, and transfer notices to the consumer.

In addition to the above, the Contractor will be required to provide the following services to support the Managed Long Term Care:

- Receive and process MLTCP program enrollments, disenrollments, recertification and transfer requests received from plans and send appropriate notices to consumers.
- Develop and implement a process for review/processing of denials of enrollment, and involuntary disenrollments to be used in all counties throughout the State. Issue Denial of Enrollment notices and Fair Hearing notices, including Fair Hearing notices specific to the MLTC program.
- Develop a dispute resolution process regarding denial of enrollment/disenrollment decisions with plans. Denials will be based on Health and Safety, if the consumer's need does not meet the plan enrollment requirements. If the MLTCP proposes to involuntarily disenroll an enrollee, MLTCP provides the Contractor with supporting documentation. The Contractor will concur or disagree with disenrollment based on review of the submitted documentation; if the Contractor concurs, the Contractor must send disenrollment and fair hearing notices to enrollee; if Contractor does not concur, it must discuss with MLTCP; if not resolved, move to dispute resolution process where the Contractor confers with a third party to be determined by the Department for final resolution. These costs should be included in the unit cost for enrollment transactions.
- Attend Fair Hearings to defend decisions about denials and involuntary disenrollments.
- Review/process denial of enrollments and involuntary disenrollments. Issue Denial of Enrollment notices and Fair Hearing notices, including Fair Hearing notices specific to MLTC. Develop a dispute resolution process regarding enrollment/disenrollment decisions with plans.

The expected monthly volume of MLTC enrollments and transfers averages around 10,000 per month. This volume is not guaranteed, and actual volume will fluctuate over the term of the agreement. Involuntary disenrollments average approximately 70 per month and denial of enrollments range between 5 and 10 per month.

#### ***4.2.7.E Fully Integrated Duals Advantage – Intellectual and Developmental Disabilities (FIDA-IDD)***

For FIDA-IDD, the Contractor is responsible for conducting enrollment counseling, outreach and education leading to the enrollment of persons with developmental disabilities into a Fully Integrated Duals Advantage – Intellectual and Developmental Disabilities (FIDA-IDD) plan. The estimated number of FIDA-IDD enrolled individuals is approximately 5,000 Statewide. Because enrollment is voluntary, the Contractor will not conduct auto enrollment activities for this program.

The Contractor will maintain field staff located at Developmental Disabilities Regional Offices and other locations as specified by the State for individualized in-person assistance to consumers and designees requesting information or wishing to establish enrollment qualifications for the FIDA-IDD program and plan enrollment.

The Contractor is responsible for all aspects of enrollment support to the Department, including notice development and mailings, outreach and education, enrollment counseling, and systems support. The Contractor must coordinate enrollment activity with the Federal interface to confirm/enroll and disenroll Medicare individuals from the FIDA-IDD product.

Although enrollment is voluntary, the Contractor is expected to provide support to the Department should enrollment requirements change for this population.

### **4.3 Mailings**

Mailings are required to be generated to existing Medicaid recipients and to individuals who are not exempt or excluded from enrollment per program specific guidelines. The enrollment broker shall generate a mailing when there is a change in status in the eligibility updates received from the Department and must accomplish the mailings within five (5) business days of initial receipt of information from the State. If for some reason the Contractor cannot meet the five (5)-day timeframe, it must notify the Department. Enrollment forms printed with the household information, including case members, shall be included in the mailings. However, exempt or excluded individuals shall not have their name and personal information printed on the enrollment forms included in the routine mailings. At a minimum, these initial mailings are generated per household and must contain a cover letter that identifies eligible consumers; enrollment or other brochures; health plan list; pre-printed enrollment form; a consumer guide for choosing plans; (currently produced and supplied by the Department) and business reply envelope. A full list of materials is identified in Section 4.5 of the RFP.

The Department may add other mailings to specified populations as needed, and to support the expansion of the Medicaid Managed Care program. The Contractor must make mailing files or other documentation of mailings available to the Department for monitoring purposes in accordance with reasonable specifications and timeframes as requested by the Department.

The Contractor is responsible for the development, printing and mailing or dissemination of all mailing materials and notices. The Contractor must have systems in place to track and generate or prompt the generation of all appropriate mailings. The Contractor must also be able to generate mailings from State generated mail lists.

### **4.4 Outreach and Education Activities**

The goals of all outreach and education efforts are the enrollment of an informed consumer into the managed care program and increased community understanding and awareness of the program. In New

York City and all other designated counties, the Contractor must maintain the outreach and education campaign (e.g., written materials/flyers, audio tapes, posters, ads, presentations) targeted to meet the identified needs of diverse targeted audiences. Approaches and materials should take into account (1) population size and geographic needs, (2) language diversity, and (3) cultural diversity issues that can impact how people learn and their perspectives and experiences related to obtaining services in a managed care environment. The approach must reflect the needs of consumers, providers, health plans, and community-based organizations that routinely interact with Medicaid consumers.

#### **4.4.1 Outreach Presentations**

The Contractor shall make group presentations to Medicaid consumers appearing at the local district for an interview, application assistance or other LDSS business about the managed care program. Enrollment counselors shall also be available for face-to-face meetings with individual Medicaid consumers who have requested or require assistance, including consumers in permanent placement in a nursing home. The goal of these presentations is the enrollment of an informed consumer into the Medicaid Managed Care program. Presentations and outreach materials must reflect cultural competence and a person-centered approach. The Contractor is able to conduct these presentations and meetings virtually as long as the needs of the Medicaid consumers are met.

The Contractor will be required to conduct presentations and accept in-person enrollments in various venues including: Human Resources Administration (HRA) income support or job centers in New York City, Medicaid offices, various other community-based locations, and other sites designated by the Department as deemed necessary and appropriate. The Contractor must consult with the individual LDSS to develop the schedule for onsite presentations. This may vary by district and will be based on the volume of consumer traffic at the district. The Contractor may also be required to develop and conduct special presentations targeted to certain populations such as persons living with HIV/AIDS. The final plan for site staffing must be approved by the Department.

The Contractor is expected to have enrollment counselors who will: (1) conduct face-to-face consumer interviews and describe the concepts and benefits of managed care, including the important role of a PCP and the benefits of preventive health care services; (2) provide consumers with a comprehensive informational package of written materials, including an enrollment form, brochures, and plan lists (in English and other appropriate languages); (3) discuss the specific health needs of a consumer and other family members and make suggestions to help consumers determine the appropriate plan to select; (4) assist consumers with recertification or renewal; and (5) provide assistance to consumers in deciding which of the available plans appears best suited to meet their current health care needs.

The Contractor shall provide a clear and detailed presentation so that each consumer is sufficiently informed to select the managed care plan most appropriate for him or her and for his or her children. Each such presentation, at a minimum, shall cover:

- A. The concepts and benefits of managed care, including the important role of a Primary Care Provider (PCP) and the benefits of preventive health care;
- B. Available health plans within the service area, including available PCPs and services offered by each plan;
- C. How to access services, including policies and procedures to access family planning, appropriate use of the emergency room, and member rights and responsibilities;
- D. The importance of visiting the PCP or contacting the managed care plan as soon as possible after enrollment to solidify the relationship;
- E. The importance of accessing primary care and preventive care, including prenatal and perinatal care and well-baby and child care;
- F. How to enroll in a managed care plan and how to obtain additional information;
- G. That enrollees have a choice of more than one managed care plan, if applicable;
- H. That enrollees have a choice of more than one PCP;

- I. That enrollees must use network providers for most services, and an explanation of carved out services; and
- J. Exemptions and exclusions from the managed care program.

Consumers must also be encouraged by the Contractor to contact their provider, or the provider they wish to choose, to determine which plans he or she participates in, and to confirm whether he or she is taking new patients. If consumers request assistance contacting the provider, the Contractor shall help determine the plans with which the consumer's preferred provider participates.

When developing the presentation schedule, the Contractor shall include times and locations that are convenient for Medicaid consumers, including evening and weekend hours. Each presentation must include sufficient time for answering the questions of participants.

For Medicaid consumers who do not make a choice at the time they encounter the Contractor enrollment counselor, a mandatory notice will be sent by the Contractor once Medicaid eligibility is established, and at that time, the mandatory enrollment "clock" begins.

The Contractor shall monitor and evaluate the effectiveness of education and outreach activities and if necessary modify strategies with the approval of the Department. A survey must be developed and used to monitor Medicaid consumers' satisfaction on presentations made in the community. The Contractor must survey consumers at the time of each community presentation. The Contractor must develop a corrective action plan to address any deficiencies identified during the surveys including alternate strategies for improving the effectiveness of the program, and implement these strategies at the next community presentation.

With the discontinuance of the requirement for an initial face-to-face interview for Medicaid, the Contractor shall collaborate with the Department or its designee, to develop alternative ways in which individuals will be provided education.

The Contractor should also consider other means to target certain populations, and methods for maximizing consumer choice to achieve and maintain low auto assignment rates. The Contractor must analyze auto assignment trends and develop strategies to ensure consumer choice over assignment enrollments.

#### ***4.4.2 Face-to-face Counseling and Provider Availability***

Section 364-j 4(e)(iv) of the State Social Services Law requires local social services district and enrollment broker counselors to verify, for enrollments made during face-to-face counseling where the enrollee has a preference for particular medical service providers, that the preferred providers participate with the selected managed care plan's network and are available to serve the participant. Therefore, during face-to-face sessions, the enrollment counselors must confirm the providers' participation in the preferred plan network.

The State provides the enrollment broker with an electronic file of health plan/provider affiliations. This information is provided on a quarterly basis. However, checking the electronic file cannot satisfy the legal requirement for a phone call as required in Section 364-j 4(e)(iv).

#### ***4.4.3 Special Outreach Activities***

The Department expects to make distinct funding available for outreach activities outside those described above. The amount is subject to the Department's discretion, however it is expected that up to \$500,000 will be available each year of the contract for other outreach, education and evaluation/assessment activities proposed by the Contractor or the Department as needs arise during the contract term. The Department must approve all proposed spending for these funds. The Contractor

may choose to organize special events of various sizes that involve outreach outside of the presentations made by Contractor staff. These activities should support the other outreach efforts of the Contractor, and could include for example, activities that encourage consumers to attend educational sessions, or that target hard to reach populations, or promote an understanding of the managed care program in the community. The Contractor may contract with another entity to provide these services. These activities may involve other costs such as printing, advertising, etc. that fall outside of the Contractor's outreach staffing costs.

If the Contractor elects to use funds to engage other organizations, the Contractor shall submit a proposal with defined deliverables, the quality and quantity of which can be measured, to ensure that funds are prudently spent.

## **4.5 Program Materials**

### ***Outreach, Education and Enrollment Materials***

Outreach, education and enrollment materials include enrollment, disenrollment and exemption forms; educational brochures and pamphlets; notices and letters; comparative managed care plan lists; health assessment forms; scripts; videos and audiotapes; informational brochures; newsletters and staff training materials. All outreach, education and enrollment materials in use by the current enrollment broker will be made available to the contractor after contract award.

The Contractor must maintain these materials in adequate numbers to continue the program, and must periodically update these materials to reflect changes in the program. The Contractor shall manage the production and maintenance of these materials, under the direction and approval of the Department to meet the needs of local districts and the detailed specifications described throughout this RFP.

The Department must approve all written outreach, education, and enrollment materials, including enrollment counselor training curricula and telephone scripts, to ensure that information is comprehensive, understandable, person-centered, accurate and unbiased, and are in compliance with New York State Free Language Access Services. The Contractor must submit any revised or new materials to the Department for approval a minimum of 30 days prior to their scheduled use.

As with all outreach, education, and enrollment activities, written materials must present unbiased information to members regarding the managed care program and available health plans. While the Contractor may not recommend one health plan or provider over another to the Medicaid consumer, enrollment counselors will be expected to provide consumers with enough information to assist them in determining which health plan(s) are best suited to meet the consumer's needs and be able to explain any differences in plans or plan types. The considerations may include location, languages spoken, primary care and specialty provider networks, and hospital affiliations.

The Contractor must revise or develop and produce all materials at the fourth-to sixth-grade reading level and in multiple languages that meet the diverse needs of the New York Medicaid consumer base. At a minimum, materials must be produced in English and Spanish. Written materials must also be accompanied by the NYS Multi-Language Insert which offers Medicaid consumers translation services for 23 prevalent languages. Fundamental program pieces must be maintained in audiotape format for the low-literacy and hearing impaired population. The Contractor must allow a minimum of 10 business days for Department review of translated materials. Section 364-j(4)(t) of the State Social Services Law requires managed care programs to advise prospective enrollees in written materials related to enrollment, to verify with their providers, or the providers they prefer, that those providers participate in the selected plan's provider network and are available to serve the prospective enrollee. Therefore, the Contractor's enrollment materials must include language that advises prospective enrollees to verify with their doctors the plans with which the doctors participate.

The Contractor shall make outreach, education and other promotional materials available to providers, health plans, CBOs or other community groups, upon request by such groups, to the extent that individual requests by such groups are reasonable in the amount requested and expected delivery time. Enrollment forms must be readily available to health plans and Certified Application Counselors in an amount sufficient to meet their needs.

The Contractor will be expected to work with the Department to develop outreach strategies for hard to reach groups, for example, the Social Security Insurance (SSI) cash population, homeless individuals, consumers not having an available or accurate mailing address, and those with serious behavioral health issues.

Printed materials for direct mailings include at a minimum:

A. Enrollment mailings:

1. Mandatory introductory letters;
2. Multi-language insert with all NYS DOH required languages listed;
3. Mandatory or other appropriate program brochures;
4. Health plan lists;
5. Enrollment forms preprinted with household information;
6. Business reply envelope, (postage paid); and
7. Consumer guides.

B. Other materials necessary for the program mailings:

1. Enrollment confirmation letters/notices;
2. Enrollment denial letters/notices;
3. Health assessment forms;
4. Exemption applications;
5. Exemption approval and denial notices;
6. Fair hearing notices;
7. Disenrollment forms;
8. Disenrollment confirmation notices, including reason for disenrollment;
9. Incomplete exemption or enrollment letters/notices;
10. Reminder letters for incomplete exemption applications;
11. End of lock-in notices; and
12. Other ad-hoc notices as directed and approved by the Department.

C. Other education and outreach materials:

1. Posters;
2. Flyers;
3. Flip charts;
4. Presentation and telephone scripts;
5. Staff training materials; and
6. Electronic media presentations.

Notices must be bilingual, English/Spanish, with English on one side and Spanish on the other. Enrollment forms must be bilingual, English/Spanish. Health plan lists, brochures, exemption forms and exemption related notices, and selected other notices must be available in English and Spanish. In NYC, Enrollment forms must be bilingual, English/Spanish, with a brief message in Russian, Chinese, Italian, Korean, and Haitian Creole about how to obtain assistance in those languages and selected other notices must be also be available in Russian, Chinese, Italian, Korean, and Haitian Creole in accordance with Executive Order No. 26.

The Contractor shall produce materials necessary for other programs where differences exist from the Medicaid managed care program. This includes but is not limited to, notices specific to MLTC, and FIDA-IDD, and a single-page, two-sided plan list used in transfer packets.

The Contractor shall not be reimbursed 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.

#### **4.6 HelpLine**

The Contractor shall establish and maintain a telephone call center accessible through a Statewide toll-free telephone number and staffed by the Contractor, which shall provide information and assistance to Medicaid consumers. The call center must be located within the 48 contiguous states.

Toll-free lines shall not cost the consumer a charge for a local call. In addition, the Teletypewriter or Text Telephone (TTY) phone access and current telephone number must be maintained by the Contractor. The Contractor must have staff that speak the primary languages of English, Spanish, Russian and Chinese. The primary languages required may change as a result of changes in the demographics of the population being served. The Contractor must maintain access to third-party telephone translation services for languages that cannot be served by HelpLine staff. Approximately 80% of the calls are from NYC beneficiaries.

The HelpLine shall operate from 8:30 a.m. to 8:00 p.m. Monday through Friday, from 10 a.m. to 6 p.m. on Saturday, and on Sundays as needed in conjunction with days of special events in the community, as directed by the Department. The Contractor must have a telephone system capable of accepting, recording or providing instruction to incoming calls during other than normal business hours and measures in place to ensure a response to those calls within the next business day after the call was received.

This Statewide toll-free HelpLine shall be an accessible source of information for Medicaid consumers regarding all of the following:

- How to enroll with a health plan including phone enrollment;
- Questions/concerns regarding program policies;
- Exemption and exclusion criteria and processing, including how an exemption or exclusion may affect eligibility for enrollment and/or receipt of waiver services;
- How to select a PCP;
- How to access physical and behavioral health care;
- How to change health plans;
- Differences between types of plans available for enrollment;
- Information regarding access to the complaint process;
- Information regarding access to the fair hearing process;
- Information on provider participation in plan networks;
- Information as part of the enrollment verification process for plan-assisted enrollments;
- Information of particular interest to SSI individuals, individuals with interest in the HIV SNPs, HARPs, and other enrollment options, and individuals with interest in the Medicaid Advantage dually eligible program; and
- The HelpLine counselors shall also encourage callers to contact their provider to see what health plans he or she participates in, and whether the provider is accepting new patients.

Callers who are not currently enrolled in a managed care plan may complete a phone enrollment through the HelpLine, except those enrolling into Medicaid Advantage plans. HelpLine counselors shall discuss health plan options with the caller, and if the caller requires additional information, provide education about the key points of managed care. HelpLine staff must be able to tell callers where providers are located and how to get to the provider's site(s). During this phone enrollment, the health assessment form will be reviewed for electronic submission.

After completing the enrollment transaction, the Contractor shall send an enrollment package to the consumer's address with a notice requesting the consumer sign and return an enrollment form for the case members who enrolled via the HelpLine. The package shall include a postage paid return envelope. The Contractor, however, shall process the consumer's phone enrollment choice regardless of whether the enrollment package is completed and returned. Special accommodation processes may be required for special populations as necessary, and in response to requests from the Department.

The Contractor shall answer general inquiries from Medicaid consumers regarding the Medicaid Managed Care program and its participating managed care plans, types of plans available and differences between them, and direct specific inquiries about a particular managed care plan to the plan for response. Once an individual is enrolled with a health plan, it is expected that the individual will access the health plan's member services unit to ask questions and resolve problems regarding Department and health plan policies and procedures, including questions regarding service coverage and accessibility. Therefore, it is expected that the Contractor will forward calls from enrolled members to the health plans' member services units when appropriate.

Staff shall also be able to answer inquiries regarding languages spoken by providers participating with managed care plans in the New York State managed care program. The State will provide the Contractor with Provider Network data.

All calls related to Medicaid financial eligibility must be directed to the LDSS or NYSoH. Enrollment or program eligibility questions must be handled by the Contractor.

The Contractor is also responsible for responding to calls from consumers who reside in a district that does not utilize the enrollment broker. HelpLine staff are expected to provide to the consumer the telephone number of the managed care contact for his or her LDSS and assist in making contact on behalf of the consumer, if necessary. During the call, the consumer may be educated about some of the basic tenets of managed care and/or provided with information about which plans or providers are available in the district, and may process an enrollment request. The Contractor is expected to be able to track which district a consumer is calling from, and report that information to the Department on a monthly basis.

The Contractor shall meet the performance standards for the HelpLine described in Attachment C of the RFP.

The Contractor must have an acceptable disaster recovery plan in place in the event that the HelpLine site is disabled as specified in Section 4.6.2.

#### **4.6.1 Selection of Managed Care Plan**

The Contractor shall assist Medicaid consumers with selection of a managed care plan that best meets his or her health needs or the needs of family members who are Medicaid consumers. The Contractor must be prepared to discuss the options available, including SNP, HARP, Managed Long Term Care, Medicaid Advantage, FIDA-IDD, and mainstream Medicaid Managed Care plans. The Contractor must also possess knowledge of the current NYS waiver programs, including whether participation in a waiver program qualifies a consumer for exemption or exclusion from enrollment into any of the managed care plan types, and how managed care enrollment may affect receipt of waiver services.

Using the most recent information available from the Department and/or the managed care plans, the Contractor must assist Medicaid consumers in verifying whether their existing provider participates in one or more available managed care plans. The Contractor shall provide assistance with Primary Care Provider (PCP) and other preferred provider selection if the enrollee is prepared to make a selection. If the enrollee is not prepared to make a decision, however, the PCP selection is the responsibility of the health plan.

#### **4.6.2 Complaint System**

The Contractor must accept complaints via the HelpLine and, to the extent possible and within the Department's guidelines, assist the consumer. With regard to complaints, the Contractor shall:

- A. Develop and maintain a computer system for logging, tracking and reporting complaints, including the disposition of the complaint, received through the Helpline or other means, consistent with the Department protocols and procedures.
- B. Accept complaints and assist Medicaid consumers, as necessary, with inquiries, complaints and appeals relating to their rights, and report as directed by the Department.
- C. Attempt to resolve concerns of enrollees, including troubleshooting and triaging Medicaid consumer problems requiring attention of the Department, LDSS, or managed care plan.
- D. Report to the Department on complaints received, when the complaint was received, and whether the complaint was forwarded to the Department for follow-up, as directed by the Department.
- E. Assess the complaint and forward to the Department for follow-up. In some cases, immediate action is required dependent upon the nature of the complaint.
- F. Follow program requirements for incident reporting for identified instances of suspected abuse.

**For the Managed Long Term Care program:** The Contractor will coordinate correspondence from individuals new to Managed Long Term Care that may require more than 120 days of CBLTSS. Following an initial assessment by the statewide assessor, the Contractor will provide support services on provider affiliations, available health plan options, enrollment policies and procedures and assistance with enrollment for individuals seeking CBLTSS.

**For the Health and Recovery Plans:** The Contractor will provide a single point of entry for outreach and education for selected consumers referred for HARP enrollment and/or BH HCBS. Individuals who are referred by the Department or other providers/agencies for HARP enrollment will receive an eligibility assessment. Assessments will be used to determine whether a consumer meets program criteria for and may benefit from HARP or other managed care enrollment.

Plans are responsible for: 1) ensuring enrollees receive assessments to determine HCBS eligibility, as well as; 2) identifying the type, frequency, and/or duration of services for the purposes of developing a person-centered Plan of Care.

All assessments are conducted utilizing the UAS-NY or other standardized tool specified by the State for this purpose.

**For the FIDA-IDD program:** The Contractor will provide a single point of entry for outreach and education for selected consumers referred for enrollment into FIDA-IDD. The Contractor is not currently responsible for developing the Plan of Care, or determination and/or delivery of services identified in the assessment. This requirement could change as the program expands over time.

Assessments will be used to determine whether a consumer meets program criteria for FIDA-IDD enrollment.

Plans are responsible for: 1) ensuring enrollees receive assessments to determine HCBS eligibility, as well as; 2) identifying the type, frequency, and/or duration of services for the purposes of developing a person-centered Plan of Care.

All assessments are conducted utilizing the UAS-NY or other standardized tool specified by the State for this purpose.

#### **4.7 Fair Hearing Responsibilities**

The Contractor shall pend actions such as the sending of reminder letters, processing an enrollment application, or auto-assignment, for a Medicaid consumer when it becomes known to the Contractor that the Medicaid consumer has requested and been granted a fair hearing and aid-to-continue, prior to the effective date of an enrollment or disenrollment.

The Contractor shall also maintain adequate records that clearly document actions taken on consumers and provide that documentation, including copies of all notices, forms, and system notes on contact with the consumer, and proof of mailing, to the Department or its designees as needed for the Department or its designee to defend the actions in fair hearings. Methods must be in place to maintain records of the action, when it was taken, what notice was sent, and the exact language of the notice. Such information includes, but is not limited to, records of outreach, enrollment, disenrollment, HelpLine calls, and copies of Medicaid consumer correspondence.

When a fair hearing request involves a decision made by the Contractor, the Contractor will prepare the documentation to be used by the Department or its designee at the Fair Hearing. The Contractor shall also provide a copy of the documentation to the enrollee and the Administrative Law Judge upon request.

#### **4.8 Develop and Implement an Internal Quality Assurance Program**

The Contractor must have a written internal quality assurance (QA) plan for monitoring and improving the enrollment process and the quality of service furnished to Medicaid consumers and health plans. The QA plan must define how the Contractor will ensure that all services are delivered effectively and efficiently. The QA plan also should define the procedures and standards by which the Contractor will maintain and evaluate its performance.

The QA plan must be submitted to the Department for prior approval within thirty (30) days of approval of the contract by the Office of State Comptroller (OSC), and must include the following:

- A. QA standards for each area of evaluation listed above;
- B. Description of the QA procedures (monitoring, documenting and evaluating);
- C. Frequency of QA activities;
- D. Identification of departments or individuals responsible for QA activities; and

E. Examples of QA evaluation tools.

The Contractor must develop a comprehensive QA program for the enrollment process and should work with the Department on determining the specific nature and extent of all periodic and ad hoc monitoring of the enrollment process, including, but not limited to:

- A. Monitoring live on-line and in-person enrollment and HelpLine staff knowledge, presentation skills, and success in communicating information to consumers;
- B. Assessing the adequacy of each counselor's training and understanding of program and its requirements through periodic staff testing and surveys of Medicaid consumers;
- C. Reviewing enrollment statistics to ensure nonbiased enrollments by counselors (e.g., there is not a disproportionate number of enrollments being processed by any counselor for any specific plan);
- D. Monitoring activities at LDSS offices, Contractor offices, and other off-site locations related to education/enrollment; and
- E. Testing and validating the accuracy and timeliness of all enrollment data entry activities.

At a minimum, the following specific QA tasks should be included in the Contractor's QA plan:

- A. Observe and document the findings for each counselor assigned to field presentations, by both Contractor and sub-contracted entities, if any;
- B. Monitor and document the findings for each enrollment counselor assigned to the HelpLine, including call recording;
- C. Review and document the findings for enrollment applications for each counselor;
- D. Review and document the findings for the review of batches of enrollment applications created in the mailroom and batches of enrollment applications returned to the mailroom from an enrollment supervisor or their designee;
- E. Review and document outcomes of plan enrollments received from managed care plans as applicable;
- F. Develop and implement a quality assurance instrument (i.e., questionnaire) to measure consumers' satisfaction and obtain comments on presentations made in the community. The intent of the questionnaire is to provide a mechanism for quick feedback on the content and effectiveness of the presentations;
- G. Monitor the development, editing, printing, and implementation process for new or revised written materials such that materials produced are accurate and implemented within mutually agreed-upon time frames. The Contractor shall not be reimbursed for the printing of 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 reprinting of materials that are found to be in error, except when such materials or information were provided by the Department; and
- H. Quality assurance mechanisms in place ensure that the appropriate written materials are being used in mailings. This includes QA systems to prevent the use of outdated materials, old versions of letters or other materials that have been revised, etc. In addition, the development of materials must include adequate review by the Contractor to ensure that all changes or modifications that have been requested the Department have been accurately accomplished.

The frequency of the above activities will be determined in coordination with the Department. It is expected that the frequency of reviews and monitoring will be affected by past performance of individuals or program areas to best utilize QA staff resources and focus on potential problem areas.

The Contractor must periodically provide written reports, including pertinent documentary support, to the Department describing the results of their enrollment process QA efforts and documenting on the internal controls implemented to improve the enrollment process. As problems are identified, the Contractor must provide early warning to the Department and managed care plans as appropriate.

The Department, or its designee, has the right to perform unannounced performance reviews or observations and to obtain documentation or recordings of calls and other contracted activities.

## **4.9 Staffing**

### **4.9.1 Organizational Structure/Staffing**

The contractor must ensure that the project is adequately staffed with experienced, knowledgeable personnel who can meet all responsibilities outlined throughout this RFP, including the performance standards specified in Attachment C. Areas of importance, including, but not limited to, systems, quality assurance, call-center or HelpLine operations, and education/outreach materials, must be adequately staffed at all times during operational phases of the contract that results from this RFP. Given the scope of services and complexity of the Medicaid managed care program in New York, it is essential that adequate supervisory staff in terms of experience and numbers are in place to manage the services described by this RFP.

Key management staff includes the Project Manager and Managers who oversee the following functions: HelpLine, systems analysis/data entry, education and enrollment counselors, and quality assurance.

The Contractor must provide the Department initially and annually thereafter, with an updated New York project organizational chart, depicting each functional unit of the organization, numbers and types of staff for each function, identified lines of authority governing the interaction of staff, and relationships with major subcontractors. The names of management personnel must be shown on the organizational chart.

The Contractor must employ and train staff necessary to complete the agreed-upon tasks at the performance standard levels specified by the contract. Job descriptions of all key staff must be provided to the Department upon contract award notification and upon any change once a contract is in place. The Department reserves the right to reject any proposed management personnel based on inadequate qualifications, poor references, or knowledge of previous inadequate performance. In addition, the Department may request changes in staff based on performance and quality.

#### **A. Key Staff**

The Contractor must assign the following Key Staff positions under the resulting contract:

1. One (1) full time New York Project Manager who must have managerial training and experience and a managed care, health-related and/or systems background. Knowledge of New York managed care providers, social services programs, health care advocacy groups, and geography is strongly preferred as well. The Department must be notified in writing, in advance, if there will be a change in the Project Manager. The notice must include an explanation for the change, and the name and credentials of the individual proposed to assume the position. In addition, the bidder must designate a deputy or second-in-command who can assist and complement the abilities of the project manager. The Department retains the right of final approval.

2. At least one (1) full time Manager will be assigned to each of the following areas below:

- HelpLine Counselor Staff
- Systems Analysis/Data Entry Staff
- Education and Enrollment Counselors
- Quality Assurance/Reporting
- Other Program Managers as specified by the Department

Managers assigned to the areas above must have knowledge and experience in the area the Manager is assigned.

Any changes or additions in key staff once the contract has begun must be reported to the Department with resumes of replacement key staff of equal or better qualification(s) submitted to the Department for prior approval before staff begins employment 10 business days prior to onboarding. The Department retains the right to request the removal of staff for cause, and to increase or decrease approved staffing levels to reflect programmatic changes.

## **B. Other Staff**

### **1. Supervisors**

The Contractor will be required to assign Supervisors to the resulting contract. Supervision staffing must be adequate to ensure proper direction and adequate oversight of employees. Supervisors must possess supervision experience and knowledge of their assigned area.

### **2. Counselors**

The Contractor will be required to provide Counselors in the local district offices or other locations designated by the State. It is expected that the field staff could be deployed interchangeably between State and local offices as designated by the State. The number of staff necessary at each district will vary depending on the eligible population of the county and the anticipated volume of eligibility and renewal appointments. The Contractor is expected to assign at least one (1) full time person on site (with a possible exception for counties with only one managed care plan), unless otherwise directed by the Department. Staff may be shared between counties with approval from the State. Currently, there are approximately 150 enrollment counselors; approximately half of these are at sites in NYC.

Counselors should exhibit strong communications and interpersonal skills. The Contractor should employ bilingual and/or multilingual staff in order to accommodate the language requirements described in Section 4.5.

### **3. System Analysts**

Systems Analysts must maintain awareness of policy changes within the New York Medicaid managed care program (proposed or otherwise) so that they can efficiently and effectively make the necessary system/process adjustments.

### **4. Research Staff**

The Contractor must also ensure that adequate staff are available and trained to respond to internal research and analysis needs, or research requests from the Department or managed care plans, for research into specific cases, to determine if systems or procedural problems exist that affect the

enrollment program. These research requests are ongoing, and are essential to ensuring that the Contractor's systems are functioning appropriately. The Contractor shall have qualified staff that routinely monitor available data to preempt problems that affect the program, and report problems and potential solutions to the Department.

The Contractor shall hire staff in sufficient numbers and who possess technical skills to accommodate the needs of the program including language skills and cultural sensitivities appropriate to accommodate the needs of Medicaid consumers. The Contractor must employ other qualified and experienced personnel necessary to successfully implement the project and carry out its operations.

In all sites where field staff are located, the county or regional office is expected to provide a work area in the form of a booth, desk, chair, etc. The Contractor must provide its own computer equipment. Accessibility to other business machines varies between districts. The Contractor must be aware that phone line access within offices may be limited and other arrangements may therefore need to be made for on-site counselors. The Contractor should work with each LDSS to provide enrollment counselors with telephone line access. The Contractor will be responsible for providing enrollment counselors with all necessary administrative materials to carry out assigned work. In some local districts, the Contractor will have access to printers and copiers and in others they will not.

#### **4.9.2 Organize and Attend Meetings**

The Contractor must be available for regional/virtual meetings and/or conference calls as may be determined by the Department on all aspects of this contract. In addition, the Contractor must meet with other Department contractors virtually as requested by the Department or as deemed necessary by the Contractor to ensure a coordinated flow of information. The Contractor will also need to meet with the contracted health plans virtually to exchange information regarding each health plan and to provide the managed care organizations with an overview of the Contractor function related to the managed care program overall or specific aspects of the program including the implementation of changes or new enrollment initiatives. In some instances, the Contractor shall organize and lead such regional/virtual meetings with the health plans. The Contractor must, at the Department's request, virtually meet with other interested parties or groups such as, but not limited to, community advocates, the legislature, other State agencies, and provider groups. If requested, the Contractor must prepare presentation materials or reports for such meetings. The Contractor must obtain approval from the Department prior to meeting with such groups.

All contacts with media organizations regarding work under this RFP must be approved by the Department in advance. The Contractor shall not make public statements related to any aspect of the New York Medicaid managed care program without the approval of the Department.

#### **4.9.3 Maintain an Operational Work Plan/Policies and Procedures**

The Contractor shall maintain a policy and procedures manual for each enrollment broker project and a county-specific appendix as approved by the Department, and instruct appropriate Contractor staff in its content. The Contractor shall also develop detailed work plans for specific tasks as directed by the Department. Each work plan is subject to review and approval of the Department. This may include new managed care initiatives, the addition of new counties to the Agreement, or other projects or program changes as presented by the Department.

#### 4.9.4 Staff Support

The Contractor is expected to have staff on site at each of the LDSS offices, unless waived by the Department, and other locations designated by the Department, to provide in-person education about managed care to consumers who are at the district office for an interview, application assistance, or other LDSS business. The list of LDSS offices by county can be found at the link below: [https://www.health.ny.gov/health\\_care/medicaid/ldss.htm](https://www.health.ny.gov/health_care/medicaid/ldss.htm).

The number of staff required to be present at assigned locations will vary based upon the volume of transactions conducted in the locality and in accordance with Department requirements. The Contractor is expected to have additional field staff designated to travel to specified locations for the purposes of conducting education and enrollment activities, as well. During the educational session, consumers are informed that, unless eligible for an exemption or exclusion, they must enroll in a managed care plan. Consumers eligible for enrollment are told which managed care plans are available in the county of residence and that they can enroll during the session. Consumers should be informed that if they are applying for Medicaid or Temporary Assistance and do not choose a plan at this time, they will be auto-assigned upon case opening as outlined in Section 4.2.3.

Effective April 1, 2010, the requirement for Medicaid applicants to have a face-to-face interview was discontinued. However, application assistance must be provided when requested by the consumer. The Contractor will be expected to work with the Department, or its designee, to determine the most efficient way to meet with Medicaid applicants who appear at local district offices for application assistance to submit required documentation, for the purposes of recertifying Medicaid eligibility, have important documents copied, or fulfill other requirements. The Contractor is also expected to develop other ways to outreach to applicants to educate and enroll; such ways may be unique to each LDSS. For certain populations, such as those in permanent placement in a nursing home, who are currently incarcerated, or those whose condition requires communication in person, the Contractor must meet with the consumer at the nursing home, place of residence, or other location most appropriate to meet the needs of the consumer and/or authorized representative. The Contractor is able to complete these meetings virtually as long as the needs of the consumer and/or authorized representative are met.

#### 4.10 Reporting

Unless otherwise indicated below, the Contractor must provide the following reports to the Department, in a format prescribed by the Department on a monthly basis:

- A. A monthly status report that summarizes all enrollment activity including the number and types of: mailings, HelpLine calls, enrollments, exemptions/exclusions, and presentations;
- B. Enrollment summaries, by borough or county and by health plan, of all accepted enrollment transactions, including enrollment choice, verification enrollments (form received first, call received first), auto-assign defaults, case additions, phone enrollments, enrollments, transfers, and disenrollments.
- C. Exception reports (current period and cumulative since mandatory enrollment began) that summarize exemptions and exclusions requested, granted or denied, by category of exemption or exclusion, and for denials, reason for denial.
- D. HelpLine call activity including number of calls by day, voicemail rates, and abandonment rates.
- E. Total number of complaints sorted by managed care plan, category, and resolution.
- F. Disenrollment summary by plan and reason.
- G. Returned mail report.
- H. Number of enrollments by plan and aid category.

- I. Written reports, including documentation describing the results of their enrollment process quality assurance efforts and documenting on the internal controls implemented to improve the enrollment process.
- J. Number of individual and group presentations, if any; the attendance at each presentation; information about cancellations; language of the presentation, (e.g. Spanish, Russian, etc.); and the resulting number of enrollments generated.
- K. Automatic or auto-assignments by managed care plan assigned (not adjusted for eligibility), borough or county, and mandatory phase where applicable.
- L. Reports required by other provisions of this Agreement, including, but not limited to, reports on financial matters.
- M. Total number of enrollment verification calls and sub-totals on the success, failure, or other outcome, of the calls.
- N. Reports specific to the performance incentives described in Attachment C in detail for the Department to evaluate re-payment of the allowed retainage.
- O. Reports specific to program type including SSI enrollments, HIV SNP, HARP, or others as requested by the Department.
- P. Post-enrollment survey of consumers assisted through enrollment processes excluding the process conducted by the Contractor to evaluate whether they were given information on the managed care plan options. The survey is conducted by phone on a quarterly basis with a minimum of 150 completed surveys each quarter.
- Q. Such other reports as the Department shall reasonably require.

Sample reports will be made available to the selected Contractor after award.

The Contractor must maintain an extremely flexible reporting capability and must be able to respond to ad-hoc reporting requests, as well as changes in the standard reporting package. It is expected that the Department and/or local districts will often request reports on specific topics. It is essential that these ad hoc reports are completed in a reasonable amount of time ranging from immediate or same day to several days, depending on the urgency and scope of the request, in order to allow the Department to make certain policy decisions related to the program. The Contractor's data system must be designed to easily retrieve the data necessary for such requests. The requests are likely to be related to enrollment, evaluation/assessment and disenrollment requests; exemption requests and decisions; special analyses (e.g., duplicate Client Identification Numbers (CIN), third party health insurance match, assessment performance and outcomes); and mailing activity, including the outcome of specific cohorts of mailings; and HelpLine calls.

The Contractor will be expected to conduct a post-enrollment survey of consumers assisted through enrollment processes excluding the process conducted by the Contractor to evaluate whether they were given information on the managed care plan options. The survey is conducted by phone on a quarterly basis with a minimum of 150 completed surveys each quarter.

All reports shall be complete and accurate. Specific data sets shall also be provided to the Department as requested.

#### **4.11 Information Technology**

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

#### **4.12 System Requirements**

The Contractor must develop and maintain the secure computer systems necessary to carry out the enrollment-related functions described in this RFP. Due to the complexity of the Medicaid managed care program in New York and the large total number of transactions that occur, it is essential that the system

accurately manage these data. This includes all Medicaid eligibility data provided by the State as well as updates to that data. It is expected that the Contractor will generate additional data during the operation of the program, such as new exemptions and exclusions, mailing information, response information, documentation of phone calls, documentation of attendance at outreach sessions, documentation of evaluations and assessments, etc. that will become part of the Contractor's database, and will affect actions on individual consumers. The system must be designed to distinguish consumers' current enrollment status, lock-in status, eligibility status, place of residence, exemption status, fair hearing status, and other information provided by the State or local district, or generated by the Contractor, that impacts whether a consumer can, cannot, or must join a managed care plan, the managed care product/s for which the consumer is eligible, or whether the consumer qualifies for evaluation or assessment.

The Department expects that the Contractor will be able to make changes to the data system in a reasonable amount of time, dependent upon the scope of the change and the detail provided by the Department. The initial design, additional programming and changes to existing programming must be done accurately and tested to determine functionality. Quality Assurance mechanisms must be in place to ensure the system is functioning properly and all critical processes are occurring on time. Where problems are found, the Department shall be promptly notified, especially where enrollments fail because of Contractor or State systems failures, or individuals are improperly enrolled or disenrolled because of Contractor or State systems failures. When appropriate, the Contractor may also be required to notify managed care plans and/or individual consumers.

The eligibility database of record for the State Medicaid program is the Welfare Management System (WMS). Local districts enter new Medicaid cases, make changes to existing cases, and end eligibility as appropriate, on WMS. WMS also reflects managed care enrollment for Medicaid consumers. The State eMedNY data system is used for a variety of purposes, such as serving as a system for Medicaid providers to verify the eligibility status of Medicaid consumers. WMS updates eMedNY daily with eligibility information. In turn, eMedNY provides daily updates on eligibility information and periodic reconciliation files to the Contractor. The Contractor must submit managed care enrollment transactions daily to the State via the eMedNY system in a HIPAA-compliant format.

The Contractor shall ensure that systems and files meet State and federal requirements including HIPAA. Currently, enrollment files exchanged between the enrollment broker and health plans, and the enrollment broker and the State systems, are HIPAA-compliant. The consumer and managed care program data that is maintained on the current contractor database will be available for the new contractor. However, bidders must have their own database system to accept and manage the data. Specifically, the Contractor shall:

- A. Establish and maintain telecommunications lines with eMedNY (Electronic Medicaid New York) or WMS, or successor systems, the Department, including NYSoH, other relevant government agencies and health plans, and provide an automated system capable of communication with eMedNY, WMS, NYSoH and the Department, and of meeting the Contractor's obligations hereunder;
- B. Establish and maintain the real-time system capability to communicate with eMedNY, NYSoH or WMS;
- C. Establish and maintain system capabilities to communicate with the Department, to perform activities, including but not limited to the following:
  1. Establish maintain, and update a database approved by the Department, necessary to perform functions within the Agreement;
  2. Maintain a daily file and record all enrollments, disenrollments, assignments, transfers, exclusions and exemptions, by reason, daily record of assessment schedules and completions;
  3. Assign as appropriate each Medicaid Consumer who has not made a choice of managed care plan, to a managed care plan according to the procedures and algorithm designed by the

Department; and

4. Develop and maintain capabilities to stop and re-start the auto-assignment process for individual Medicaid consumers.
- D. Establish and maintain system capabilities to communicate with the participating health plans (e.g. electronic bulletin board) to perform activities including but not limited to, the exchange and tracking of enrollment information, and must work with the health plans to ensure the data exchange operates correctly;
- E. Permit the Department to access the Contractor's database;
- F. Maintain separate Contractor files of all processed and unprocessed enrollment applications;
- G. Maintain a disaster recovery plan that is acceptable to the Department, and demonstrate that plan at the Department's request. At a minimum, the Contractor must meet the following requirements:
  1. The disaster recovery plan must identify alternate processing sites that have been tested for use in the event of a disaster;
  2. The plan must describe the physical security at the recovery site;
  3. The contingency plan for short and long term interruption of services must be clearly described, including the frequency for testing;
  4. The plan must indicate that the Contractor has identified critical business and data practices and ensured their availability at times of high system resource utilization; and
  5. The plan shall indicate how critical data is duplicated or backed up.
- H. Maintain the procedures, provisions, conditions, and equipment for the security of its processing site. The Department or its designee shall have the unconditional right to make security inspections of the Contractor's organization at any time, without notice to the Contractor. If the Department shall request additional security provisions, the Contractor shall not unreasonably delay or refuse to adopt the same.

All systems outlined above will be subject to the review and approval of the Department.

#### **4.13 Security**

The selected Contractor shall comply with all privacy and security policies and procedures of the Department (<https://its.ny.gov/system/files/documents/2025/02/nys-p03-002-information-security.pdf>) and applicable State and Federal law and administrative guidance with respect to the performance of the Contract. The Contractor is required, if applicable, to execute a number of security and privacy agreements with the Department including a Business Associate Agreement (Appendix H) and a Data Use Agreement (DUA) at contract signing.

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

The Contractor is required to maintain and provide to the Department upon request their data confidentiality plans and procedures for meeting security requirements as they relate to the deliverables and services within this RFP, including all plans as they relate to subcontractor work where applicable.

Contractor will develop and maintain adequate fully trained staff to respond to all stakeholder inquiries while protecting confidentiality and maintaining the security and integrity of all systems. Staff must be trained to understand and observe requirements related to confidentiality and operating guidelines for functions included in this RFP.

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

#### **4.14 Transition**

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

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

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

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

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

#### **4.15 Payment**

The contractor shall submit invoices and/or vouchers to the State's designated payment office:

Preferred Method: Email a .pdf copy of your signed voucher to the BSC at: [DOHaccountspayable@ogs.ny.gov](mailto:DOHaccountspayable@ogs.ny.gov) with a subject field as follows:

Subject: Unit ID: 3450426 <Contract #C040633>

Alternate Method: Mail vouchers to BSC at the following U.S. postal address:

NYS Department of Health  
Unit ID 3450000  
PO Box 2093  
Albany, NY 12220-0093

Payment for invoices and/or vouchers submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at [www.osc.state.ny.us/epay/index.htm](http://www.osc.state.ny.us/epay/index.htm), by email at [epayments@osc.state.ny.us](mailto:epayments@osc.state.ny.us) or by telephone at 518-474-6019. CONTRACTOR acknowledges that it will not receive payment on any invoices and/or vouchers submitted under this Contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9 must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at <http://www.osc.state.ny.us/epay>.

Completed W-9 forms should be submitted to the following address:

NYS Office of the State Comptroller  
Bureau of Accounting Operations  
Warrant & Payment Control Unit  
110 State Street, 9th Floor  
Albany, NY 12236

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

The Contractor must furnish the Department with sufficient evidence, vouchers, bills and receipts as required by the Department as proof of proprietary expenditure of each initial payment. Payments to Contractor will be reimbursed based on monthly invoices to the Department in accordance with the approved prices included in the awarded bidder's Attachment B: Cost Proposal.

Invoices shall be submitted by the tenth (10th) business day of the month following the month of service. Costs shall be separated by local district. Shared costs shall be allocated between the local districts serviced under the resulting contract using a method approved by the Department. Requests for reimbursement shall be supported by adequate documentation to support the payment and shall contain sufficient detail such that the Department can identify and evaluate the appropriateness of the charges. The Department may request copies of vendor invoices and any other related source documents.

The Contractor shall reduce the monthly claim for each core performance category (mailings, enrollment, HelpLine, outreach, and systems by ten percent (the "retainage"). This reduction shall be reflected in the total of each monthly invoice. The Contractor may bill the Department for the retainage if the performance standards are met. The Department will consider each core performance category independently. If the performance standards for a category are met for the month of measurement, the retainage amount for that category will be reimbursed to the Contractor. If performance standards are not met for the month of measurement, the retainage for that month shall only be returned to the Contractor if the standards are met in the following month (e.g. if the March retainage is withheld, it will be returned if the Contractor meets the standards for April). The retainage shall not be returned if the standards are not met in the following month.

Performance standards for each core performance category are listed in Attachment C.

### **Price Adjustment Clause**

The pricing for years four (4) and five (5) of the Contract will be subject to an annual increase or decrease of the lesser of three percent (3%) or the percent increase or decrease in the National Consumer Price Index for All Urban Consumers (CPI-U) (CUUR0000SA0), as published by the United States Bureau of Labor Statistics,

Washington, D.C. 20212, for the 12 month period ending ninety (90) days prior to the commencement date for years *four (4) and five (5) of the Contract*.

#### **4.16 Subcontracting**

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

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

#### **4.17 Contract Insurance Requirements**

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

Sections 57 and 220 of the New York State Workers' Compensation Law (WCL) provide that the Department shall not enter into any contract unless proof of workers' compensation and disability benefits insurance coverage is produced. Prior to entering into a contract with the Department, successful Bidders will be required to verify for the Department, on forms authorized by the New York State Workers' Compensation Board, the fact that they are properly insured or are otherwise in compliance with the insurance provisions of the WCL. The forms to be used to show compliance with the WCL are listed below. Any questions relating to either workers' compensation or disability benefits coverage should be directed to the State of New York Workers' Compensation Board, Bureau of Compliance at (518) 486-6307. Failure to provide verification of either of these types of insurance coverage by the time contracts are ready to be executed will be grounds for disqualification of an otherwise successful Proposal. The successful Bidder must submit the following documentation before a contract may take effect.

##### **A. Proof of Workers' Compensation Coverage:**

ONE of the following forms as Workers' Compensation Coverage:

1. **Form C-105.2** - Certificate of Workers' Compensation Insurance issued by private insurance carrier (or Form U-26.3 issued by the State Insurance Fund); or
2. **Form SI-12** - Certificate of Workers' Compensation Self-Insurance (or Form GSI-105.2 Certificate of Participation in Workers' Compensation Group Self-Insurance); or
3. **Form CE-200** - Certificate of Attestation of Exemption from New York State Workers' Compensation and/or Disability Benefits Coverage.

##### **B. Proof of Disability Benefits Coverage:**

ONE of the following forms as Disability documentation:

1. **Form DB-120.1** – Certificate of Disability Benefits Insurance; or
2. **Form DB-155** – Certificate of Disability Benefits Self-Insurance; or

### 3. **Form CE-200** – Certificate of Attestation of Exemption from New York State Workers' Compensation and/or Disability Benefits Coverage

Further information is available at the Workers' Compensation Board's website, which can be accessed through this link: <http://www.wcb.ny.gov>.

#### **4.18 Minority & Women-Owned Business Enterprise (M/WBE) Requirements**

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

#### **Business Participation Opportunities for M/WBEs**

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

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

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

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

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

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

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

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

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

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

#### **4.19 Participation Opportunities for NYS Certified Service-Disabled Veteran-Owned Businesses**

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

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

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

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

## **5.0 ADMINISTRATIVE INFORMATION**

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

### **5.1 Restricted Period**

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

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

This prohibition applies to any oral, written, or electronic communication under circumstances where a reasonable person would infer that the communication was intended to influence this procurement. Violation of any of the requirements described in this Section may be grounds for a determination that the bidder is non-responsible and therefore ineligible for this contract award. Two (2) violations within four (4) years of the rules against impermissible contacts during the “restricted period” may result in the violator being debarred from participating in the Department’s procurements for a period of four (4) years.

## **5.2 Questions**

Potential Bidders may submit written questions and requests for clarification pertaining to this RFP between the issuance of this RFP and the deadline for the submission of written questions specified in Section 1 (Calendar of Events). All questions and requests for clarification of this RFP should cite the relevant RFP, including the RFP number and title (C040633: Enrollment Broker Services), the section and paragraph number of this RFP or of the Attachment to this RFP to which the question relates, where applicable, and must be submitted via email to [OHIPContracts@health.ny.gov](mailto:OHIPContracts@health.ny.gov) no later than the Deadline for Submission of Written Questions specified in Section 1. (Calendar of Events). Questions received after the deadline **may not** be answered.

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

## **5.3 Right to Modify RFP**

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

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

If a prospective bidder discovers any ambiguity, conflict, discrepancy, omission, or other error in this RFP, the bidder shall immediately notify the Department of such error in writing at [OHIPContracts@health.ny.gov](mailto:OHIPContracts@health.ny.gov) and request clarification or modification of the RFP.

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

## **5.4 The Department’s Reserved Rights**

The Department of Health reserves the right to:

1. Reject any or all proposals received in response to the RFP;
2. Withdraw the RFP at any time, at the Department's sole discretion;
3. Make an award under the RFP in whole or in part;
4. Disqualify any bidder whose conduct and/or proposal fails to conform to the requirements of the RFP;
5. Seek clarifications and revisions of proposals;
6. Use proposal information obtained through site visits, management interviews and the State's investigation of a bidder's qualifications, experience, ability or financial standing, and any material or information submitted by the bidder in response to the Department's request for clarifying information in the course of evaluation and/or selection under the RFP;
7. Prior to the bid opening, amend the RFP specifications to correct errors or oversights, or to supply additional information, as it becomes available;
8. Prior to the bid opening, direct bidders to submit proposal modifications addressing subsequent RFP amendments;
9. Change any of the scheduled dates;
10. Eliminate any mandatory, non-material specifications that cannot be complied with by all of the prospective bidders;
11. Waive any requirements that are not material;
12. Negotiate with the successful bidder within the scope of the RFP in the best interests of the State;
13. Conduct contract negotiations with the next responsible bidder, should the Department be unsuccessful in negotiating with the selected bidder;
14. Utilize any and all ideas submitted in the proposals received;
15. Every offer shall be firm and not revocable for a period of three hundred and sixty-five (365) days from the bid opening, to the extent not inconsistent with section 2-205 of the uniform commercial code. Subsequent to such three hundred and sixty-five (365) days, any bid is subject to withdrawal communicated in a writing signed by the bidder; and,
16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of a bidder's proposal and/or to determine a bidder's compliance with the requirements of the solicitation.

## 5.5 Debriefing

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

## 5.6 Protest Procedures

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

## 5.7 Freedom of Information Law ("FOIL")

All Bids may be disclosed or used by the Department to the extent permitted by law. The Department may disclose a Bid to any person for the purpose of assisting in evaluating the Bid or for any other lawful purpose. All Bids will become State agency records, which will be available to the public in accordance with the New York State Freedom of Information Law. **Any portion of the Bid that a Bidder believes constitutes proprietary information entitled to confidential handling, as an exception to the Freedom of Information Law, must be clearly and specifically designated in the Bid as specified in Section 6.1.2. of this RFP.** If the Department agrees with the proprietary claim, the designated portion of the Bidder's Bid will be withheld

from public disclosure. Blanket assertions of proprietary material will not be accepted, and failure to specifically designate proprietary material may be deemed a waiver of any right to confidential handling of such material.

## **5.8 Piggybacking**

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

## **6.0 PROPOSAL CONTENT**

The following includes the format and information to be provided by each Bidder. Bidders responding to this RFP must satisfy all requirements stated in this RFP. All Bidders are requested to submit complete Administrative and Technical Proposals, and are required to submit a complete Cost Proposal. A proposal that is incomplete in any material respect may be rejected.

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

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

### **6.1 Administrative Proposal**

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

#### **6.1.1 Bidder's Disclosure of Prior Non-Responsibility Determinations**

Submit a completed and signed [Attachment 1](#), "Prior Non-Responsibility Determinations."

#### **6.1.2 Freedom of Information Law – Proposal Redactions**

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

#### **6.1.3 Vendor Responsibility Questionnaire**

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

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

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

#### **6.1.4 Vendor Assurance of No Conflict of Interest or Detrimental Effect**

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

#### **6.1.5 M/WBE Forms**

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

#### **6.1.6 Encouraging Use of New York Businesses in Contract Performance**

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

#### **6.1.7 Bidder's Certified Statements**

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

#### **6.1.8 References**

Provide references using [Attachment 9](#), (References) for three similar engagements. Provide firm names, addresses, contact names, telephone numbers, and email addresses.

#### **6.1.9 Diversity Practices Questionnaire**

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

#### **6.1.10 Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination**

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

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

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

### **6.1.12 State Finance Law Consultant Disclosure Provisions**

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

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

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

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

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

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

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

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

Submit these Forms, available through these links:

- ST-220 CA: [http://www.tax.ny.gov/pdf/current\\_forms/st/st220ca\\_fill\\_in.pdf](http://www.tax.ny.gov/pdf/current_forms/st/st220ca_fill_in.pdf)
- ST-220 TD: [http://www.tax.ny.gov/pdf/current\\_forms/st/st220td\\_fill\\_in.pdf](http://www.tax.ny.gov/pdf/current_forms/st/st220td_fill_in.pdf)

## **6.2 Technical Proposal**

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

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

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

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

**A. Title Page**

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

**B. Table of Contents**

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

**C. Documentation of Bidder's Eligibility Responsive to Section 3.0 of RFP**

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

The Department will accept proposals from organizations or individuals with the following types and levels of experience as a prime contractor. The Department will accept proposals from organizations possessing:

A Minimum of five (5) years of experience related to the following:

- Bidder must have at least 5 years' experience with:
- Performing Enrollment Broker services for a Medicaid program with at least 500,000 beneficiaries;
- Providing Call Center support for health plan choice counseling and enrollment broker services for Medicaid population of at least 500,000;
- Performing Medicaid Enrollment activities for potential beneficiaries;
- Performing Managed Care Enrollment activities for a population of at least 1,000,000;
- Providing Managed Care Education in person, by phone and by mail;
- Performing or managing Large Scale Mailing Projects of at least 50,000 mailings; and
- Operating a consumer-facing customer service center/call center that handles high volumes (at least 15,000 calls per day) of telephone calls.

Experience acquired concurrently is considered acceptable.

For the purposes of this RFP, a prime contractor is defined as one who has the contract with the owner of a project or job and has full responsibility for its completion. A prime contractor undertakes to perform a complete contract and may employ (and manage) one or more subcontractors to carry out specific parts of the contract,

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

## **D. Technical Proposal Narrative**

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

Elements of the Technical Proposal are as follows:

### **D.1. Corporate Background and Experience**

- i The bidder should describe its organizational experience with the tasks associated with this RFP. This should include specific project descriptions, which should include the client's name, duration of the project, a description of the scope of services provided and a description of project components that are similar to the services defined in this RFP. The bidder shall provide a listing and description of five projects taking place within the past five years that involved one or more of the following activities as one of the project's major components:
  - a. Medicaid Enrollment
  - b. Managed Care Enrollment
  - c. Managed Care Education
  - d. Large Scale Mailing Programs
  - e. Consumer Relations
  - f. Outreach/Public Relations
  - g. Data Systems Development and Operations

### **D.2 Enrollment/Disenrollment Activities**

- i Provide an overview of the bidder's relevant experience with enrollment programs such as those described in Section 4.2, and how that experience is applicable to the programs described.
- ii Describe the approach to fulfilling the requirements for enrollment processing described in Section 4.2.1, within the timeframes stated and with appropriate checking for eligibility, exemption or exclusion status, and fair hearing status.
- iii Describe the experience with data systems that clearly demonstrate the ability to receive electronic enrollments from health plans as described in Section 4.2.1, and provide feedback to plans on the receipt of those files, and the result of each transaction.
- iv Describe how bidder plans to process and coordinate all forms to ensure enrollment effective the first of the next month as described in Section 4.2.1.
- v Describe the Bidder's procedures for disenrollment processing, including how the bidder will determine who is eligible to disenroll to fee for service Medicaid, or transfer to another plan, the timing of disenrollment processing, notification of consumers, notification of managed care plans, etc. as described in Section 4.2.6.
- vi Describe how the bidder plans to develop and maintain data systems to track a consumer's mandatory or voluntary status.
- vii Describe how the bidder will support the Department's efforts to reduce disenrollments resulting from a failure to recertify Medicaid eligibility, including outreach activities to consumers, notification to managed care plans and other strategies.
- viii Describe the bidder's experience with conducting phone surveys similar to the Post Enrollment Surveys described in Section 4.2.5.

#### **D.2.a Determination of Eligible Individuals/Exemption and Exclusion Processing**

- i The bidder should describe how it plans to work with individuals who may be exempt or excluded from mandatory enrollment in the various Medicaid managed care products, including Managed Long Term Care plans, and assist individuals in applying for exemption or exclusion status as described in Section 4.2.2. Also, the bidder should include a description of how the bidder will work with the local districts in the different approval processes described in Section 4.2.2.
- ii The bidder should describe how it will manage the eligibility, exemption, and exclusion data provided by the Department as described in Section 4.2.2. Describe how this function will be accomplished electronically, on a daily basis. Describe how this data system will be capable of tracking exemption requests and decisions, preventing further actions from taking place on those beneficiaries whose requests are being processed, such as routine mailings requiring enrollment or auto-assignment to a plan.
- iii The bidder should describe how it will work with consumers regarding their potential exemption or exclusion status, as detailed in Section 4.2.2. This includes describing how staff will be dedicated to helping consumers complete and process the exemption and exclusion forms. Describe how the bidder's staff will be able to discuss the exemption categories with callers and identify the one or more exemptions that the consumer may apply for. Describe the case management approach that will lead to granting the consumer the most favorable type of exemption and if exemption requests are denied, assisting the consumer to enroll in a plan that meets his/her needs.
- iv The bidder should describe how it will, within 3 business days, review all exemption requests, and if incomplete, contact enrollees to complete missing information, as outlined in Section 4.2.2.
- v The bidder should describe how it will assist in processing timely disenrollments related to exemption and exclusion requests of persons already enrolled in a plan, including expedited disenrollments for persons eligible.

**D.2.b Auto-assignment**

- i Describe the bidder's experience that would demonstrate the ability to manage the auto assignment process described in Sections 4.2.3.
- ii Describe the planned role of the data system in the auto-assignment process, including a discussion of how the system accounts for consumers who have moved since the original notice was sent, lost eligibility or applied for exemption or exclusion status, had an exemption or exclusion approved since the process began, or asked for a fair hearing. Describe how the system can be expanded to accommodate new populations.
- iii Describe the bidder's method for monitoring and tracking auto-assignments.

**D.2.c HIV Special Needs Plans**

- i Describe the bidder's approach to meet the requirements described in Section 4.2.7.A related to HIV Special Needs Plans, including but not limited to a description of the bidder's training of enrollment counselors in the differences between Special Needs Plans and the other managed care plans, and any differences in enrollment procedures and confidentiality rules.
- ii Provide a detailed description of how the bidder will accommodate requests from persons living with HIV AIDS who live in NYC about managed care enrollment.
- iii Describe the bidder's ability to promptly mail information packets to consumers who call or otherwise request additional information regarding HIV SNPs.

**D.2.d Health and Recovery Plans (HARP)**

- i Describe the bidder's approach to meet the requirements described in Section 4.2.7.B related to Health and Recovery Plans, including but not limited to a description of the bidder's training of enrollment counselors in the differences between Health and Recovery Plans and the other managed care plans, and any differences in enrollment procedures and confidentiality rules.
- ii Provide a detailed description of how the bidder will accommodate requests from persons living with serious mental illness, substance use disorders, and serious behavioral health issues about managed care enrollment.
- iii Describe the bidder's ability to promptly mail information packets to consumers who call or otherwise request additional information regarding HARPs.

**D.2.e Medicaid Advantage Plus (MAP)**

- i Describe how the bidder will ensure timely enrollment to the Medicaid Advantage plans as described in Section 4.2.7.C, including allowing enrollment up until the last business day of the month, for enrollments effective the first of the next month.
- ii Describe how staff will be assigned to act as a contact to assist in resolution of enrollment issues to ensure that the Medicare Advantage enrollment and the Medicaid Advantage enrollment are in sync.

**D.2.f Partially Capitated Managed Long Term Care (MLTC)**

- i Describe the bidder's process for reviewing denials and requests for involuntary disenrollments. Include in the description the staff responsible for reviewing documents provided by the MLTC to support their request, their experience and the training that will be provided to staff. Include in the discussion a description of how the bidder will ensure that appropriate notices will be sent including fair hearing notices when appropriate.
- ii Describe the bidder's dispute resolution process for resolving enrollment/disenrollment issues with plans about denials and involuntary disenrollments.

**D.2.g Programs of All-Inclusive Care for the Elderly (PACE)**

- i Describe how the bidder will ensure timely enrollment to the PACE plan as described in Section 4.2.7.D, including allowing enrollment up until the last business day of the month, for enrollments effective the first of the next month.
- ii Describe how the bidder will coordinate enrollment activity with the Federal interface to confirm/enroll, and to disenroll consumers in receipt of Medicare.

**D.2.h FIDA-IDD**

- i. Describe how the bidder will ensure timely enrollment to the FIDA-IDD plan as described in Section 4.2.7.E, including allowing enrollment up until the last business day of the month, for enrollments effective the first of the next month.
- ii. Describe how the bidder will coordinate enrollment activity with the Federal interface to confirm/enroll, and to disenroll consumers in receipt of Medicare.

**D.3. Mailings**

- i Describe how the bidder will use files of Medicaid Consumer information supplied by the Department as described in Section 4.3 to conduct a targeted mailing to mandated populations within five business days of initial receipt of information from the State, and the selection process for choosing who shall receive mailings. Describe how, at a minimum, these initial mailings will contain such materials described in section 4.5 of the RFP.

- ii In accordance with the mailing schedule described in Section 4.3, explain how the bidder will mail to each Medicaid Consumer who has not enrolled or made a choice of Medicaid Managed Care plan within 30 days, or a Managed Long Term Care plan within 60 days, of the bidder's initial mailing, a notification that the consumer is being assigned to a plan and which plan. Describe how the bidder will mail to each newly eligible Medicaid Consumer who has not enrolled or made a choice of managed care plan a notification advising the Consumer that he/she is being auto assigned to a health plan and which plan.
- iii Describe how the bidder is capable of maintaining the flexibility to conduct additional targeted mailings such as those targeted as described in Section 4.3 concurrently with the routine mandatory mailings.
- iv Describe the how the bidder will develop and maintain data systems that can track and generate, or prompt the generation of all appropriate mailings, phone calls, and track return mail.

#### **D.4 Outreach and Education Activities**

- i Provide a description of the bidder's experience performing outreach and education tasks and how that experience can be applied to the requirements described in Section 4.4.
- ii Describe how the bidder will conduct the information sessions described in Section 4.4.1. Include the process for routing, scheduling, and tracking requests for in-person meetings if necessary, examples of meeting sites, and the frequency/availability and geographic distribution of such meetings. Describe how consumers will be made aware of the information sessions available to them, and how the bidder proposes to encourage both attendance and enrollment into managed care plans at these sessions.
- iii Describe how the bidder proposes to use the additional funds described in Section 4.4.3 for special outreach activities. Explain how the proposed activities will contribute to the overall managed care enrollment program. Describe the process that will be used to evaluate the effectiveness and efficiency of each type of outreach/educational effort, especially the special outreach activities that fall under Section 4.4.3.
- iv Discuss how the bidder will gain access to and serve communities, including hard-to-reach populations, populations with complex physical and behavioral health needs, and culturally and linguistically diverse areas of New York City.
- v Describe the approach to assisting consumers with the selection of a PCP. Include a description of the process to comply with the State Social Services Law Section 364-j requirements described in Section 4.4.1.

#### **D.5 Materials and Advertising**

- i Describe the bidder's experience managing the development and production of a large number and variety of printed materials and notices that demonstrates the ability to meet the requirements for written materials described in Section 4.5.
- ii Provide additional detail regarding the approval process for revising or developing new written materials, training curricula, etc. as described in Section 4.5.
- iii Explain how the bidder will manage the translation of revised and new written materials and audiotapes, described in Section 4.5, and the bidder's experience managing translations.
- iv Provide a description of how the materials in Section 4.5 will be maintained, and (as needed) developed, for effective outreach and education of the eligible population to be enrolled.
- v Describe examples of the types of written materials that will be distributed in order to inform the public about the program.

## **D.6 HelpLine**

- i Describe the bidder's experience that demonstrates the ability to establish and maintain a HelpLine in accordance with the program requirements in Section 4.6.
- ii Explain how the bidder proposes to effectively utilize HelpLine staff to direct callers to health plans' member services units for questions about access to benefits, complaints, or other issues with which the health plans should be involved.
- iii Describe the HelpLine staff's capabilities in answering inquiries regarding providers who participate in managed care plans, and languages spoken by managed care plan participating providers and how to identify the location of provider sites. Include in the description a discussion of how calls from non-participating counties will be handled.
- iv Describe the bidder's complaint system in accordance with the specifications in Section 4.6.2, including the role of staff and the tracking systems used to monitor the status of complaints.

## **D.7 Contract Responsibilities and Staffing**

### **D.7.a Quality Assurance**

- i Describe the bidder's quality assurance program and how the program will assure acceptable functioning of the data systems, including a discussion of the areas described in Section 4.7.1.
- ii Describe how the bidder will ensure timely notification of the Department of any operational issues detected during the course of routine business.

### **D.7.b Implementation and Work Plan**

- i Describe bidder's recruitment plan for ensuring ideal staffing levels. Include bidder's methodology for determining the appropriate number and sites for offices.
- ii Describe bidder's proposed computer and data system, including hardware and software used for each type of major function, and how or if the bidder intends to use equipment purchased by the Department under previous enrollment broker contracts.
- iii Explain bidder's general approach to manage and/or plan for the major work tasks. Include a proposed work plan and timeline showing major milestones to complete operation.

### **D.7.c Staffing Plan**

- i Submit job descriptions and qualifications for each key staff position identified in Section 4.8.1. Identify bilingual or multilingual staff and the languages that they speak.
- ii Provide a description that demonstrates the bidder's ability to dedicate the necessary resources required to provide the requested services. This should include a focus on data system(s) capacity and corporate support.
- iii The bidder should provide, as described in Section 4.8.1, all information regarding language needs, experience, supervision, quality assurance, and systems staffing should be fully addressed
- iv Attach all relevant organizational charts and charts of proposed staffing levels, with titles. The organizational chart should include all the functional units required by the RFP in Section 4.8.1.
- v Provide the proposed training strategy to train new staff, and maintain continuing education, or refresher training, for existing staff.
- vi Describe the bidder's proposal to staff the program. The response should demonstrate how the bidder will ensure a person is clearly designated as a lead contact for NYC and other regions as

defined by the State on routine issues, who will be knowledgeable of the different policies and procedures in those counties.

- vii Describe how a policy and procedure manual will be maintained, what staff shall maintain the manual, how the manual will be made available to staff, and how changes to the manual will be made available to staff.
- viii Describe how the bidder will coordinate with each LDSS to determine office space availability and telephone data access.

## **D.8 Systems and Data Reporting**

- i Describe the bidder's experience with and capabilities to meet all data exchange and reporting requirements, including a full description of the systems development and maintenance necessary to fulfill the system requirements described in this RFP and specifically in Section 4.11. In addition, the response should explicitly describe the system abilities to meet the flexibility, timeliness and quality needs of the Department described in Section 4.1. Describe the bidder's ability to modify systems to respond to an expansion of the broker's responsibilities that may result from State takeover of the local district responsibilities for the Medicaid Program.
- ii Describe how the bidder will develop its disaster recovery plan including the minimum requirements outlined in Section 4.11. Bidders do not have to submit an actual disaster recovery plan with the proposal, however the response should demonstrate a full understanding of disaster recovery procedures and how the bidder will apply its experience in disaster recovery in the event of a natural, man-made or technological event when developing an acceptable plan for the Department specific to this project.
- iii Describe the bidder's system security, confidentiality, HIPAA and HITECH policies and regulations, and explain how these will be implemented. Include a discussion of physical security elements, software security elements, staff training in confidentiality protocols, and consumer representation protocols.
- iv Describe how the bidder will maintain flexible reporting capability and ability to respond to ad-hoc reporting requests, as well as changes in the standard reporting package.
- v Describe the bidder's process for maintenance of records that clearly document actions that have been taken on such consumers and provide such documentation to the local district as needed for that district to defend the actions in a State Fair Hearing described in Section 4.2.7.D.

## **6.3 Cost Proposal**

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

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

## **PROPOSAL SUBMISSION**

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

Submit a complete Proposal via email to: [OHIPcontracts@health.ny.gov](mailto:OHIPcontracts@health.ny.gov) with the subject "Offer *RFP C040633 and Enrollment Broker Services*". Include, as attachments to the email, three complete distinct PDF files

labeled “Administrative Proposal”, “Technical Proposal” and “Cost Proposal”. In the event an electronic submission cannot be read by the Department, the Department reserves the right to request a hard copy and/or electronic resubmission of any unreadable files. The Bidder shall have 2 business days to respond to such requests and must certify the resubmission is identical to the original submission. Hardcopy will prevail.

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

### **7.1 No Bid Form**

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

## **METHOD OF AWARD**

### **8.1 General Information**

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

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

The evaluation process will be conducted in a comprehensive and impartial manner, as set forth herein, by an Evaluation Committee. The Technical Proposal and compliance with other RFP requirements (other than the Cost Proposal) will be weighted **70%** of a proposal's total score and the information contained in the Cost Proposal will be weighted **30%** of a proposal's total score.

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

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

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

### **8.2 Submission Review**

The Department will examine all proposals that are received in a proper and timely manner to determine if they meet the proposal submission requirements, as described in [Section 6.0](#) (Proposal Content) and [Section 7.0](#) (Proposal Submission), including documentation requested for the Administrative Proposal, as stated in this RFP. Proposals that are materially deficient in meeting the submission requirements or have omitted material documents, in the sole opinion of the Department, may be rejected.

### **8.3 Technical Evaluation**

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

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

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

The Technical Proposal evaluation is **70% (up to 70 points)** of the final score.

#### **8.4 Cost Evaluation**

The Cost Evaluation Committee will examine the Cost Proposal documents. The Cost Proposals will be opened and reviewed for responsiveness to cost requirements. If a cost proposal is found to be non-responsive, that proposal may not receive a cost score and may be eliminated from consideration.

The Cost Proposals will be scored based on a maximum cost score of 30 points. The maximum cost score will be allocated to the Cost Proposal with the lowest all-inclusive not-to-exceed maximum price. All other responsive proposals will receive a proportionate score based on the relation of their Cost Proposal to the Cost Proposal(s) offered at the lowest final cost, using this formula:

$$C = (A/B) * 30\%$$

A is Total price of lowest Cost Proposal;

B is Total price of Cost Proposal being scored; and

C is the Cost score.

The Cost Proposal evaluation is **30% (up to 30 points)** of the final score.

#### **8.5 Composite Score**

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

#### **8.6 Reference Checks**

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

#### **8.7 Best and Final Offers**

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

#### **8.8 Award Recommendation**

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

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

## ATTACHMENTS

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

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

The following attachments are attached and included in this RFP:

- A. Proposal Document Checklist
- B. Cost Proposal
- C. Performance Standards
- D. Additional Background Information

**ATTACHMENT A  
PROPOSAL DOCUMENT CHECKLIST**

Please reference Section 7.0 for the appropriate format and quantities for each proposal submission.

<b>RFPXX-XX – Enrollment Broker Services</b>		
<b>FOR THE ADMINISTRATIVE PROPOSAL</b>		
<b>RFP §</b>	<b>SUBMISSION</b>	<b>INCLUDED</b>
§ 6.1.1	Attachment 1 - Bidder's Disclosure of Prior Non-Responsibility Determinations	<input type="checkbox"/>
§ 6.1.2	Freedom of Information Law – Proposal Redactions (If Applicable)	<input type="checkbox"/>
§ 6.1.3	Attachment 3 - Vendor Responsibility Attestation	<input type="checkbox"/>
§ 6.1.4	Attachment 4 - Vendor Assurance of No Conflict of Interest or Detrimental Effect	<input type="checkbox"/>
§ 6.1.5	M/WBE Participation Requirements:	<input type="checkbox"/>
	Attachment 5 - Form 1	<input type="checkbox"/>
	Attachment 5 - Form 2 (If Applicable)	<input type="checkbox"/>
	Attachment 5 - Form 4	<input type="checkbox"/>
	Attachment 5 - Form 5 (If Applicable)	<input type="checkbox"/>
§ 6.1.6	Attachment 6 - Encouraging Use of New York Businesses	<input type="checkbox"/>
§ 6.1.7	Attachment 7 - Bidder's Certified Statements	<input type="checkbox"/>
§ 6.1.8	Attachment 9 - References	<input type="checkbox"/>
§ 6.1.9	Attachment 10 - Diversity Practices Questionnaire	<input type="checkbox"/>
§ 6.1.10	Attachment 11 - EO 177 Prohibiting Contracts with Entities that Support Discrimination	<input type="checkbox"/>
§ 6.1.11	Attachment 12 – EO 16 Contracting with Businesses Conducting Business in Russia	<input type="checkbox"/>
§ 6.1.12	State Finance Law Consultant Disclosure	<input type="checkbox"/>
§ 6.1.13	Sales and Compensating Use Tax Certification	<input type="checkbox"/>
<b>FOR THE TECHNICAL PROPOSAL</b>		
<b>RFP §</b>	<b>SUBMISSION</b>	<b>INCLUDED</b>
§ 6.2.A	Title Page	<input type="checkbox"/>
§ 6.2.B	Table of Contents	<input type="checkbox"/>
§ 6.2.C	Documentation of Bidder's Eligibility (Requirement)	<input type="checkbox"/>
§ 6.2.D	Technical Proposal Narrative	<input type="checkbox"/>
<b>FOR THE COST PROPOSAL REQUIREMENT</b>		
<b>RFP §</b>	<b>REQUIREMENT</b>	<b>INCLUDED</b>
§ 6.3	Attachment B- Cost Proposal	<input type="checkbox"/>

**ATTACHMENT B - COST PROPOSAL**  
**RFP #C040633**

**INSTRUCTIONS**

Overview

Bids should be developed with the goal of continuing what was previously developed with relation to printed brochures, notices, forms, and other existing materials that represent the program Statewide. Bidder should be clear about what materials or equipment they propose to develop, purchase new, or that will be supplied by subcontractors.

In addition, bidders should develop bids assuming the continuation of the mandatory Medicaid managed care, including the expansion and reform of the Medicaid program.

Bid Form

The Bidder must present the total all inclusive, not to exceed per unit costs for each of the following program areas, using the Offeror's Bid on Program Areas – Cost Worksheet found on the Bid Form in Attachment B. In determining monthly volume, activities for all service areas shall be combined to determine the applicable payment rate. When considering the per unit cost levels, please note that payment will be based on the volume of activity in one month and the specific per unit cost for that volume level, not a combination of two levels.

1. Enrollment/Disenrollment Activities
2. Mailings
3. Outreach and Education Activities
4. Development and Implementation of an Internal Quality Assurance Program
5. Program Materials
6. HelpLine

All other than those described under "Additional Costs" at the end of this section, must be contained within the above program cost areas. This includes costs for furniture and equipment purchasing, and/or rental, property rental/leasing, postage, administrative costs, systems development and maintenance, reporting costs, overhead, fringe, and fees, etc. The program cost areas are described below. It is expected that the contractor will provide a discount as volume increases.

The prices proposed by the bidder in the cost worksheets will be held in effect for the full five years of the initial contract period, unless the Department determines that significant program changes necessitate an amendment to those prices. The prices may be eligible for an inflationary increase of the lesser of three percent or the percent increase in the National Consumer Prices Index for all Urban Consumers (CPI-U) as published by the United state Bureau of Labor Statistics, Washington D.C. 20212, for the three-year period ending 180 days prior to contract year three. This provision does not apply to the Additional Costs rate; this rate will not be increased during the contract period. As with all State contracts, the duration of the contract is subject to availability of funds.

Mailings

Bidders shall propose a total all inclusive, not to exceed per unit cost for conducting the mandatory and voluntary mailings as described in Section 4.3, within the ranges shown below. The per unit measurement specifies only the initial mandatory packets and the voluntary mailing packets mailed. At a minimum, the following should be included in the mailing cost proposal: startup costs, cost of

producing the mailing packets, including the materials specified in Section 4.5 of this RFP; staffing, equipment; the productions of the reminder mandatory mailings to those household, that do not respond to the initial mandatory mailing, as described in Section 4.2 of this RFP; and the postage necessary to carry out the initial mailings and the reminder mailings. The per unit price paid is determined by the total number of mailings in the month. Actual payment will not bleed multiple tiers or prices. For example, if 38,000 mailings are sent in a month, the payment due to the Contractor is 38,000 multiplied by the price per mailing at the 25,001-60,000 level. The volume the Department expects, but does not guarantee, is approximately 30,000 per month.

#### Enrollment Application Processing

Bidders shall provide a total all-inclusive, not to exceed per unit cost for each enrollment processed to completion. The per unit bid price shall include the costs associated with processing the enrollment applications to completion as described in Section 4.2.1. Enrollment costs must include startup costs, including the survey or a sample enrolled by Certified Application Counselors (CAC) and Community Base Organizations (CBO); exemption and exclusion processing; auto assignment processing; HIV SNP, HARP, FIDA-IDD, Medicaid Advantage Plus and Managed Long Term Care Plan, and other enrollments as specified by the Department; transition enrollments including disenrollments and transfers; health assessment forms; the cost of producing and providing enrollment forms to health plans, Certified Application Counselors and community Base Organizations; and all notices associated with these processes.

- Reimbursement will be based on the per unit bid amount, depending upon volume of unduplicated enrollment applications processed to completion. Unduplicated enrollments are those enrollment transactions that result in an error free enrollment or a correct enrollment denial. An enrollment must be denied when a person is not eligible to be enrolled, e.g. a person who is receiving Medicare. Paper and electronic transactions are eligible for reimbursement, including transfers.
- The Contractor will not be paid for duplicated enrollments. Duplicate enrollments may be an enrollment that was mishandled by the Contractor, and therefore must be processed again; or enrollment for a consumer who completes a phone enrollment and subsequently mails in an enrollment form. The Contractor will not be paid for pending enrollment or for duplicate enrollments that result when errors or mistakes that are within the Contractor's control, cause a transaction to fail, or otherwise remain incomplete. The Contractor will not be paid for transfers resulting from terminations or acquisitions in which consumer are assigned to a default plan. The Contractor will be paid for transactions resubmitted by health plans. Auto assignments are not eligible for reimbursement.

The per unit price paid is determined by the total number of enrollments in the month and per unit price level info which that total volume fails. Actual payment will not blend multiple tiers or prices. The volume the Department expects, but does not guarantee, is approximately 40,000 a month.

#### HelpLine Activities

Bidders shall propose a cost for a total all inclusive, not to exceed per unit price to provide HelpLine services covering all activities described in Section 4.6, including managing incoming information calls, verification calls, complaints and outreach calls to potential auto-assignees. The proposed costs shall, at a minimum, including staffing and equipment, including computers, necessary to provide these services to all programs, including HIV SNP, HARP, FIDA-IDD, Medicaid Advantage, Medicaid Advantage Plus, and Managed Long Term Care Plans, or other programs as specified by the Department. The unit is defined as a call that is answered by a live person or a call made by HelpLine

staff in response to a message left on the HelpLine. The expected, but not guaranteed, volume is approximately 90,000 calls per month.

#### Outreach and Education Activities/Field Staffing

Bidder shall propose a per FTE total all inclusive, not to exceed cost for a baseline level of 140 Contractor staffing to provide outreach and education as described in Section 4.4 of this RFP. This includes, but is not limited to, the costs for Contractor staff; production of materials necessary for all presentation and outreach sessions such as brochures, enrollment forms, flip charts, and other material specified in Section 4.5; local travel for field staff; and equipment to support outreach activities, including computer. Reimbursement shall be for the amount proposed for the baseline staffing, and for each additional staff person as approved by the Department, at the incremental cost proposed by the bidder. The baseline was chosen based on experience with the presentation responsibilities, and the expectation that there would be certain efficiencies as staff are added over the baseline levels. The baseline and incremental staff costs proposed must not include the costs of these other activities such as the sub-contracting with community organizations except in as much as the Contractor staff are used to train and monitor the community organization(s).

#### Systems, Reporting, and QA Staffing

Bidders shall propose a per FTE total all inclusive, not to exceed cost for a baseline level of 40 staff to maintain the systems and reporting functions necessary to support the enrollment, education and outreach, HelpLine, and mailings program described in this RFP, including the specific systems-related functions and specifications described in Section 4.5 and the QA program described in Section 4.7.1. The costs shall include at a minimum; all staff dedicated to systems, reporting and QA, and all hardware, software, and shared system operating time related to running and maintaining the data systems required for the program described in this RFP. Reimbursement shall be for the amount proposed for the baseline staffing, and for each additional staff person as approved by the Department at the incremental cost proposed by the bidder. The baseline was chosen based on experience with the systems, QA, and reporting responsibilities and the expectation that there would be certain efficiencies as staff are added over the baseline levels. Bidders must include a contingency that describes how the Department will be billed if the FTE level should fall below the baseline level.

#### Additional Costs related to Special Outreach Activities

Certain program activities will be reimbursed to the Contractor on a costs basis plus a fee. Bidders shall propose a fee rate for these activities, not to exceed 20%. The Department prior to commencement of such work must approve any such work by the Contractor. Activities include development work to revise the existing written enrollment, education, outreach materials, or the development of new materials also included in the placement of mediate and advertising, and revision or any of the existing media materials.

**Vendor must complete the following form.**

**ATTACHMENT B - COST PROPOSAL FORM**

Please complete all white cells in the “Per Unit Price/Cost” and “Annual Estimated Cost” columns.

<u>Offeror's Bid on Program Areas</u>	<u>Per Unit Price/Cost</u>	<u>Monthly Estimated Quantity*</u>	<u>Monthly Estimated Cost</u>
<b>Number of Mailings Completed</b>	<b>Per Unit Price</b>		
Up to 25,000 mailings per month	\$_____ per voluntary mandatory initial mailing		
25,001 to 60,000 mailings per month	\$_____ per voluntary mandatory initial mailing	30,000	\$
Over 60,000 mailings per month	\$_____ per voluntary mandatory initial mailing		
<b>Monthly Enrollment Applications Processed</b>	<b>Per Unit Price</b>		
Up to 30,000 enrollment packages processed per month	\$_____ per enrollment packages processed		
30,001 to 60,000 enrollment packages processed per month	\$_____ per enrollment packages processed	40,000	\$
Over 60,001 enrollment packages processed per month	\$_____ per enrollment packages processed		
<b>HelpLine Activities</b>	<b>Per Unit Price</b>		
Up to 75,000 calls per month	\$_____ per call		
75,001 to 150,000 calls per month	\$_____ per call	90,000	\$
Over 150,000 calls per month	\$_____ per call		
<b>Outreach/Field Staffing</b>	<b>Cost</b>		
Baseline staffing of 140 FTE	\$_____ per FTE per month	140	\$
<b>Systems, Reporting, and QA Staff</b>	<b>Cost</b>		
Baseline staffing of 40 FTE	\$_____ per FTE per month	40	\$
<b>Additional Costs related to Special Outreach Activities</b>	_____ % on all approved additional costs (estimated \$500,000 annually)	-	\$

**ATTACHMENT C**  
**RFP # C040633**  
**Contractor Performance Standards**

The Contractor is expected to fully meet all requirements and maintain the staffing necessary to perform the tasks described in the scope of work and any subsequent contract task expansions. The Department has selected specific Contractor responsibilities on which to measure performance. Performance is measured across all local districts combined unless stated elsewhere in this section.

Performance is measured on a monthly basis. The Contractor shall reduce the monthly claim for each core performance category (mailings, enrollment, HelpLine, outreach, and systems) by ten percent (the “retainage”). This reduction shall be reflected in the total of each monthly invoice submitted by the Contractor.

The Contractor may bill the Department for the retainage if the performance standards are met. The Department will consider each core performance category independently. If the performance standards for a category are met for the month of measurement, the retainage amount for that category will be reimbursed to the Contractor. If performance standards are not met for the month of measurement, the retainage for the measurement month shall only be returned to the Contractor if the standards are met in the following month (e.g., if the March retainage is withheld it will be returned if the Contractor meets the standards for April). The retainage shall not be returned if the standards are not met in the following month.

Performance standards for each core performance category are listed as follows:

**Mailings**

- 95% of initial enrollment packet mailings to identified populations within five (5) days of the initial receipt of the information files from the Department.
- Less than 5% of initial enrollment packet mailings go to exempt or excluded populations known to the Contractor at the time of mailing.
- Routine internal quality assurance standards for mailings are followed and met in accordance with the QA plan approved by the Department.
- Notification of the Department within 24 hours of any instance when there is a delay in routine mailings to mandatory populations.

**Enrollment Application Processing**

- 95% or more of hardcopy enrollment forms processed within three (3) business days.
- 97% of electronic files and phone enrollments processed within one (1) business day.
- 95% or more of plan choice confirmation notices mailed within three (3) business days of acceptance.
- 95% of exemption forms reviewed and responded to within three (3) business days of receipt.
- Routine quality assurance standards for enrollment processing are followed and met in accordance with the QA plan approved by the Department.

**Outreach and Education Activities**

- Monthly auto-assignment rate is below 30% for NYC and 30% for all Non-NYC local districts served. Rates will be calculated separately for NYC and for all other local districts served.

- Routine quality assurance standards for field presentations are followed and met in accordance with the QA plan approved by the Department. Any alteration of the frequency or strategy for monitoring Education and Enrollment Counselors shall only be made with prior approval of the Department.

### **HelpLine**

- 80% or more of calls answered with a live voice.
- Average waiting/hold time for a live voice less than 2 minutes.
- 95% or more of calls returned within 24 hours.
- Abandoned call rate is less than 8%.
- Routine quality assurance standards for HelpLine are followed and met in accordance with the QA plan approved by the Department. Any alteration of the frequency or strategy for monitoring HelpLine Enrollment Counselors (shall only be made with prior approval of the Department).

### **Systems and Reporting**

- Complete and accurate weekly reports, as prescribed by the Department, must be delivered by noon on the Wednesday of the week following the week of the report.
- Complete and accurate monthly reports, as prescribed by the Department, must be delivered by the tenth business day of the month following the month of the report.
- Priority systems changes are completed and tested within agreed-upon timeframes
- Routine quality assurance standards for systems maintenance and reports are followed and met.

## **ATTACHMENT D**

### **Additional Background Information**

#### D.1 Medicaid Managed Care (MMC) Program

NYS has operated a Medicaid managed care (MMC) program under State law for more than two decades. In March 1995, the Department submitted an application under Section 1115 of the Social Security Act to the Centers for Medicare and Medicaid Services (CMS) requesting approval of a demonstration project to implement a statewide mandatory Medicaid managed care program called the Partnership Plan. The Partnership Plan Section 1115 demonstration uses a managed care delivery system to improve access to health care for the Medicaid population; improve the quality of health services delivered; create efficiencies in the Medicaid program; and enable the extension of coverage to certain individuals who would otherwise be without health insurance.

- The initial Partnership Plan demonstration was approved in 1997 to enroll most Medicaid beneficiaries into managed care organizations either on a mandatory or voluntary basis.
- In 2001, the Family Health Plus program was implemented as an amendment to the demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without children, who have income and/or assets greater than Medicaid eligibility standards.
- In 2005, mandatory managed care enrollment for SSI-eligible individuals began in New York City, and was completed in all other mandatory counties as of December 2008.
- Effective January 1, 2005 dual eligible beneficiaries in the Partnership Plan were permitted to enroll on a voluntary basis into one managed care plan for both Medicare and Medicaid services (a Medicaid Managed Care Organization (MCO) and a Medicare Advantage Plan). New York has two different programs, Medicaid Advantage and Medicaid Advantage Plus, which includes long term care services, to enroll the dual-eligible population.
- In 2006, the State submitted a request and received approval for a second Section 1115 waiver the “Federal-State Health Reform Partnership (F-SHRP)”. This waiver authorizes the State to implement reform initiatives that will improve quality of care and result in long-term savings for the State and Federal government. Effective October 1, 2006, the authority to require disabled adults and children, as well as the elderly, to enroll in the Medicaid managed care program was transferred from the Partnership Plan to the Federal-State Health Reform Partnership (F-SHRP) 4 Demonstration (11-W-00234/2). This includes individuals dually eligible for Medicare and Medicaid who are included in the F-SHRP demonstration but may enroll on a voluntary basis.
- In 2007 the waiver was amended again to allow the State to enroll Family Health Plus-eligible individuals with access to employer-sponsored insurance into the employer sponsored insurance plan if that coverage is more cost-effective than providing direct coverage under Family Health Plus. The State provides “wrap-around” services through fee-for-service to complement the employer benefit package to ensure that individuals have full access to Family Health Plus equivalent benefits.
- In January 2010, CMS approved the State’s request to begin mandatory enrollment of persons living with HIV/AIDS. Enrollment began in NYC on September 1, 2010. HIV positive beneficiaries and their uninfected children may choose to enroll in an HIV Special Needs Plan (HIV SNP). These plans provide comprehensive health services, including HIV experienced providers, case management and treatment

adherence services. The Contractor will be required to have all staff receive HIV confidentiality training. There are three operational HIV SNPs serving approximately 16,000 enrollees.

The Medicaid managed care program operates pursuant to State law, the 1115 waivers, the Terms and Conditions of both waivers, the New York State Operational Protocol and the Managed Care Model Contracts.

The 2007 version of the Operational Protocol available under "Health Insurance Programs" on the Department's website at: [http://www.health.ny.gov/health\\_care/managed\\_care/index.htm](http://www.health.ny.gov/health_care/managed_care/index.htm).

Current programmatic guidelines are contained in the Medicaid Managed Care/ HIV Special Needs Plan/ Health and Recovery Plan model contract. Managed care contracts for all programs are available on the Department website at: [http://www.health.ny.gov/health\\_care/managed\\_care/providers/index.htm#model\\_contracts](http://www.health.ny.gov/health_care/managed_care/providers/index.htm#model_contracts)

The Terms and Conditions for both waivers and Operational Protocol Appendices are available at the link above. New York's mandatory Medicaid managed care program covers most non-institutionalized Medicaid beneficiaries, not in receipt of Medicare. State statute, the 1115 waivers and the Terms and Conditions of the two waivers define specific groups who are not eligible to join managed care or are exempt from enrollment. These groups are identified in Chapter 2 of the Operational Protocol.

Implementation of mandatory enrollment authorized by the waiver began in October 1997 in five upstate counties. Mandatory enrollment is now implemented in forty-five counties and in all five boroughs of New York City. Total enrollment is approximately 5,000,000, Enrollment data can be found at the Department's website at [http://www.health.ny.gov/health\\_care/managed\\_care/reports/enrollment/monthly](http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly).

## D.2 Managed Long Term Care (MLTC)

Managed long-term care (MLTC) helps people who are chronically ill or have disabilities and who need health and long-term care services, such as home care or adult day care, stay in their homes and communities as long as possible. The MLTC plan arranges and pays for a large selection of health and social services and provides choice and flexibility in obtaining needed services from one place. There are two basic models of managed long-term care in New York State: Managed Long Term Care Plans and Programs of All-Inclusive Care for the Elderly (PACE).

### D.2.1 Managed Long-Term Care Partially Capitated Plans (MLTCP)

Managed long-term care plans provide long-term care services (like home health and nursing home care) and ancillary and ambulatory services (including dentistry, and medical equipment), and receive a Medicaid capitation payment. Members get services from their primary care physicians and inpatient hospital services using their Medicaid and/or Medicare cards. Members must be eligible for nursing home admission.

In New York City Managed Long Term Care program enrollments, disenrollments and transfer requests are submitted to the broker by the LDSS. The broker generates all appropriate enrollment notices.

### D.2.2 Medicaid Advantage Plus (MAP)

Under MAP a dual eligible recipient enrolls in a single health plan for most Medicare and Medicaid covered services. Certain Medicaid services are still obtained through the fee-for-service system. Enrollment in Medicaid Advantage Plus is voluntary statewide.

### D.2.3 Programs of All-Inclusive Care for the Elderly (PACE) Organizations

A PACE organization provides a comprehensive system of health care services for members age 55 and older who are otherwise eligible for nursing home admission. Both Medicare and Medicaid pay for PACE services (on a capitated basis). PACE members are required to use PACE physicians and an interdisciplinary team develops care plans and provides on-going care management. The PACE is responsible for directly providing or arranging all primary, inpatient hospital and long-term care services required by a PACE member.

### D.3. Current Enrollment Broker Services

The enrollment broker currently provides services in New York City and all other local districts that have implemented mandatory enrollment with the exception of: Chautauqua, Delaware, Orleans, Seneca, Tompkins and Wyoming. Six (6) counties operate a mandatory Medicaid managed care program without the services of the enrollment broker, and 7 counties have a Voluntary MMC program only.

Enrollment broker services include: educating eligible individuals about managed care; mailing enrollment materials to eligible individuals; processing enrollment and disenrollment transactions; processing requests for exemptions and exclusions; maintaining a toll free help line; and developing and producing written materials for the Medicaid managed care. This includes: Mainstream Managed Care; HARP; HIV SNP; Partially Capitated Managed Long Term Care; PACE; Medicaid Advantage Plus; and FIDA-IDD programs.

The State provides the enrollment broker with a full file of Medicaid eligibility and daily updates for all local districts. The enrollment broker sends mailings to individuals who appear on the file as eligible for enrollment based on transactions in the daily files including changes, case updates, openings and renewals. These mailings inform individuals of the need to enroll as well as provide information that assist the individuals in making a plan choice. The mailings include an enrollment form pre-printed with the consumer information such as name, address, Medicaid client identification number, and names of household members. Enrollments can be submitted on hard copy, directly from the Medicaid consumer, or the consumer may call the broker's HelpLine to enroll. If these forms are pre-printed, indicating that the consumer received a mailing from the broker, they are processed for enrollment to the health plan chosen by the consumer.

The written materials for the program consist of member notices related to enrollment, disenrollment, exemption request approvals/denials, etc. and health plan lists. Each program, (MMC and MLTC), has its own notices and each notice must include specific information about each local district, (e.g. phone numbers, contacts, plans, etc.). New notices must be developed when program policies change, or new programs are introduced and need to be produced quickly when needed.

Health plans play an active role in marketing to and enrolling current Medicaid consumers. The health plans may submit enrollments electronically to the enrollment broker through a system established and maintained by the broker. The enrollments are only processed if the individual has received education through a mailing from the enrollment broker or attended a community presentation on managed care. If the person has not received such unbiased education, the individual must telephone the enrollment broker for enrollment counseling before the enrollment can be finalized. This "verification" process

ensures that the individual is aware of the choices of plans available and the basic tenets of managed care. The exception to this rule is with new applications through the facilitated enrollment process.

In counties other than NYC, health plans submit facilitated enrollments to the enrollment broker at the same time the Medicaid eligibility application is sent to the LDSS. The managed care choice is sent to the enrollment broker and the eligibility application is sent to the LDSS. The managed care choice is systematically pended while the eligibility application is reviewed. After the LDSS establishes the eligibility, the pended enrollment is matched to the newly established eligibility, and the consumers are enrolled into the health plan of their choice. The broker must have a system capable of tracking the pended applications. In New York City, the HRA eligibility workers enter the Medicaid eligibility information as well as the managed care enrollment that are established through the facilitated enrollment process. The enrollment information is then transmitted electronically to the broker to generate the enrollment notice.

The broker has staff on site at each of the LDSS offices, or other sites designated by the Department, to provide in person education about managed care to consumers who are at the district for an interview, application assistance, or other LDSS business. During the educational session, consumers are informed if they live in a MMC mandatory county, and if not eligible for an exemption or exclusion, must enroll in a Mainstream managed care plan. Eligible consumers are told which Mainstream managed care plans are available in the county and that they can enroll during the session, or if they do not choose a plan at that time, a mailing will be sent to them advising that they will have to choose a health plan or one will be chosen for them.

The toll-free HelpLine established by the broker handles approximately 9,000 calls per day statewide. The same HelpLine is used for all counties. In addition to English, the call center must be able to accommodate people who speak Spanish, Russian, Chinese and any other language the State identifies. The contractor must use a telephone language translation service if a counselor is not available who speaks a caller's language.

Effective April 1, 2010, the broker became responsible for responding to calls from consumers who reside in a district that does not utilize the enrollment broker. Call center staff are expected to give the consumer the number of the managed care contact in their LDSS and assist in making contact with that LDSS, if necessary. An extensive data system has been developed which is used to manage and support many aspects of the enrollment and education program. The data base includes all Medicaid eligibility information provided by the state, daily updates to that information, managed care enrollment information, exemptions and exclusions, documentation of consumer encounters through the HelpLine, complaint information, information on mailings, and documentation of fair hearing requests. Detailed reports are produced routinely using the data elements contained in the enrollment broker data system. The data system triggers most of the mailings required by the program.

The data system tracks the status of Medicaid consumers in the designated counties serviced by the broker, selects consumers who must be educated about enrolling, and auto-assigns those required to join who fail to do so in the allowable time frame. For consumers required to enroll who do not select a health plan after having received multiple notices and who are not exempt or excluded, the system uses an algorithm developed by the Department to assign consumers to those plans authorized by the Department to receive auto-assignments. Auto-assignments are grouped by household, and the assigned health plan must serve the consumer's area and have adequate capacity as defined by the Department. The auto-assignment process is monitored closely and the Department calculates an auto-assignment rate using a methodology approved by CMS.

The enrollment broker's data system has been programmed to provide extensive feedback to health plans on enrollment transactions. The enrollment broker also works closely with health plan staff in group meetings and one-on-one in order to clarify enrollment procedures and troubleshoot plan enrollment files.

All electronic enrollment data files exchanged between the health plans and the enrollment broker, and the enrollment broker and the state data systems, are in a HIPAA-compliant file format.

#### D.4 Facilitated Enrollment

The Department currently oversees a program of "facilitated enrollment", as authorized by state statute, where community-based organizations and health plans provide education, outreach and enrollment services to individuals who are without health insurance, or who must transition from the Child Health Plus to Medicaid. The facilitated enrollers (FE) assist these individuals with completion of a Medicaid application, and if the individual resides in a mandatory county and has made an enrollment choice the FE can assist the individual with the enrollment section of the application. Approximately 18.4% of all enrollments in the counties currently receiving services from the broker were from FEs. In NYC approximately 9.6% of the enrollments came from FEs.

#### D.5 The Health Plans

There are currently eighteen full-risk Managed Care Organizations (MCOs) statewide that are contracted to operate in one or more local social service districts to enroll Medicaid and Family Health Plus consumers. Currently, there are fifteen mainstream managed care plans and three HIV Special Needs Plans operating in New York City.

The enrollment broker works closely with the health plans on enrollments, disenrollments and transfers. The health plans must be able to submit and receive HIPAA-compliant electronic files to and from the enrollment broker. Health plans communicate enrollment changes and problems directly to the enrollment broker staff that assist the plans in correcting problems or coordinate the changes with local district managed care staff. As health plans expand service areas, make changes to the benefit package or to the provider network, the enrollment broker must be able to update its data systems and printed materials, retrain staff as needed, and act as a resource for questions from consumers.

#### D.6 Potential Changes

Chapter 58 of the Laws of 2010 authorized the Commissioner of Health to develop a plan for the State to assume the administrative services of the Medical Assistance program performed by the LDSSs. The scope of work may change during the term of the contract as a result of: 1) expanding services to additional counties; 2) state assumption of functions performed by the LDSS, or 3) other changes that result from state or federal legislation.

Potential changes that may affect the broker include: expanding to additional counties; assuming functions performed by the LDSS (e.g. roster reconciliation; notices and mailings, exemption requests); processing more enrollments by phone; processing more disenrollments (retroactive disenrollments).