**Payment Questions**

1. **Q: For #4 under Funding Parameters and Evaluation Criteria, does the Prospective Payment refer only to the $10,000 Fixed Annual Charge or the entire budgeted amount ("maximum amount")? If the former, are we drawing down the payments we make to the IPM vendor on that Fixed Annual Charge before billing the activities to the contracted MCOs?**

A: Unit Charges are mandatory. Carving out a Fixed Rate is optional. Fixed Rate and Unit Charges are prospective or retrospective depending on the MCO. After determining structure and timing, the CPI decides on allocations to the vendor drawing on funds from Fixed Rate or Unit Charges. Fixed Rate guarantees a minimum nonrefundable amount of money received from MCO partners independent of volume of services. However, Fixed Rate reduces the Unit Charge.

Let's say MCO A and MCO B are the only participating MCOs. In Year 1, we expect 200 enrollments total, with 40% or 80 children from MCO A expected to get IPM-AR treatment. MCO A would pay the CPI 40% ($4,000) of the annual Fixed Rate ($10,000 in Year 1) and commits to paying for up to 80 IPM-AR units for their members over the year at Unit Charge of $900 (or lower, depending on CPI bid).

MCO A prefers to pay the Fixed Rate and Unit Charges in their quota up front. So the CPI can charge $4,000 to MCO A up front for their 40% of the Fixed Rate, and $72,000 (80*$900) up front for up to 80 IPM-AR Unit Charges.

If at the end of the year, only 50 IPM-AR units were delivered to MCO A members, then the CPI must return to the MCO $27,000 of unit charges paid prospectively (30 units*$900). Because it is Year 1, this balance can be applied to Year 2 quota for the MCO. The CPI keeps all of the Fixed Charge.

2. **Q: Is the second IPM visit for families with severe infestations covered under a separate Unit Charge or does it need to be absorbed within the first Unit Charge?**

A: The necessary number of visits to a single housing unit would all be included under a single Unit Charge for that housing unit. The CPI's contract with the IPM-AR provider should specify that service payment will be dispensed on a per-housing unit basis. The contract should include language that requires the IPM-AR contractor to provide a sufficient number of visits to adequately meet the requirements set forth in the IPM-AR protocol (per Appendix B of the RFP), as part of a pre-negotiated, per-unit cost. The NYC DOHMH can provide technical assistance to the CPI by reviewing its IPM-AR RFP and/or contract prior to finalization, upon request.

3. **Q: Related to Appendix C, is it expected that the QA visits for 20% of the completed services will be done in person by the CPI? For clarity, we assume that these QA visits would need to be factored into the Unit Charge. Is this correct?**

A: Yes, the CPI would be expected to conduct follow-up visits to at least 20% of the serviced units for the purposes of quality assurance. These visits should be factored in as part of the CPI's Unit Charge and/or Fixed Annual Rate.

4. **Q: Is there any additional money to fund the administrative portion of the CPI to operate the program?**

A: No, the applicants must factor in their administrative costs into the proposed bid. The applicant can bid for a reimbursement structure that is exclusively based on Unit Charges, and/or for one that has Fixed Annual Rate and Unit Charges. If the applicant presents a bid for both, the final determination on which type of reimbursement will be implemented with the MCOs will be done in the last stage of the Medicaid Together planning phase.

5. **Q: What does the Unit Charge include?**

A: All the activities described in the RFP as part of the scope of the CPI are to be covered via the mechanism for payment that the applicant chooses to bid for, be it Option A: Unit Charge only, and/or Option B: Fixed Rate + Unit Charge.

6. **Q: Is the unit charge $1,000?**

A: $1000 is the maximum "Unit Charge" that a potential applicant can propose if they only will charge based on units with IPM-AR treatment completed. If the CPI proposes to have a "Fixed Rate" as well, the maximum amount of "Unit Charge" must not exceed $900.

7. **Q: Can the CPI negotiate additional compensation with the MCO to cover the other aspects of asthma case management not under consideration in the RFP, such as: health literacy, medication adherence support, linkages to social services, and care planning?**

A: The Case Management component of Medicaid Together is not part of this RFP. CPI applicants must be able to fully deliver on the requirements of this RFP independent of their case management contracts with MCOs (or lack thereof). The Case Management component of Medicaid Together is intended to be delivered by the MCOs either directly or via vendors. The organization that is awarded the CPI contract is not precluded from seeking other contracts from MCOs, inclusive of contracts for Case Management.

**<u>Scope of Services Questions</u>**

1. **Q: What about mold issues found in homes, especially within NYCHA residents? Will an IPM service cover mold as well, if they have both?**

A: While mold-related services are not included as part of the IPM-AR provider's scope of work, the IPM service provider is required to document the findings from his/her home assessment (see Appendix B for more information). This includes documenting evidence of mold and/or conditions that can lead to mold (like water leaks and moisture sources), as well as any other potential allergy/asthma triggers in the home, and to submit their findings to the CPI. The CPI will share relevant home assessment findings beyond the IPM provider's scope of work with the patient's MCO case manager for appropriate follow up, as part of the CPI's routine, post-IPM service reporting.

In the case of mold, the MCO case manager will contact the patient or patient's family to confirm that there is a mold problem, and ask for the family's consent to refer them to the NYC DOHMH's Healthy Neighborhoods Program in order to address the issue. The DOHMH will follow up with the family, set up a time to conduct a home assessment, and follow up with the family's building owner over any building-related issues that are identified during the assessment in order to fix them.

2. **Q: Is DOHMH able to provide technical assistance to the CPI on the IPM-AR portion of the project?**

A: DOHMH's Healthy Homes Program can provide short-term technical assistance to the CPI when developing and implementing the following aspects of the project:

- A sample phone script for outreach to eligible families, describing the program and IPM-AR service
- Review of the IPM-AR vendor RFP and/or the IPM-AR protocol
- Conducting walk-throughs with the CPI on a portion of patient homes at the beginning of the project to ensure quality assurance after IPM-AR services.

3. **Q: What is the estimated percentage of homes that will need a second IPM visit for severe infestations?**

A: We estimate that about 10% of homes will need a second visit for severe infestations. Second visits are generally expected to be much shorter in duration and scope given that most of the IPM-AR work will be conducted during the first visit.

4. **Q: How will IPM-AR be able to work with NYCHA and similar governmental housing associations given the timeline of the grant?**

A: IPM-AR service will be provided to a household upon consent from the inhabitants of the dwelling, regardless of whether the property is public or private. This service does not require a property owner's involvement.

If, however, other housing-related problems are identified that are beyond the scope of the IPM-AR provider (e.g., large holes or cracks in walls/floors, water leaks), the CPI can either refer the issue to the patient's MCO case manager, or to DOHMH's Healthy Neighborhoods Program (HNP), for follow up. Alternately, the CPI may choose to notify the family about the HNP program and advise them to follow up with their health care provider.

## Child Eligibility Questions

1 **Q: Are children not enrolled in a participating MCO eligible for the Medicaid Together program?**

A: We received multiple questions related to specific population groups and their eligibility for Medicaid Together. For example, children in an MCO that is not participating in Medicaid Together, children in FFS

Medicaid such as children in foster care, children in CHP but not in an MCO, and children in commercial insurance.

Participating MCOs are the payers for this service, so IPM-AR services for children who do not belong to a participating MCO are outside the scope of service for this project. However, children can also be referred to DOHMH's Healthy Neighborhoods Program (HNP), upon consent, directly by the CPI. Alternately, the CPI may choose to notify the family about the HNP program and advise them to follow up with their health care provider.

After receiving a referral, the DOHMH will contact the family to confirm eligibility, set up a time to conduct a home assessment, and follow up with the building owner over any building-related issues that are identified during the assessment in order to fix them.

2. **Q: How many children enrolled in Managed Care Plans have been hospitalized in NYC as a result of Asthma this past year?**

A: Approximately 2300 children 5-17 years old on Medicaid or Child Health Plus are hospitalized due to asthma in NYC on an annual basis; the vast majority are in a managed care plan. However, hospitalization is only one of the eligibility criteria for Medicaid Together. Once allergy, exposure, residential stability, and parental consent are factored in, the CPI is expected to provide service to up to 200 children in year 1, 500 in year 2, and 500 in year 3.

**Other Questions**

1. **Q: Do you have a list of MCOs that have committed to participate in this initiative?**

A: The list is not public. The awarded CPI will be involved in the final stage of the planning process with all participating MCOs.

2. **Q: If less than 4 MCOs participate, how will the CAP be divided if they are limited to only 50 per MCO per year**

A: MCOs caps are not limited to 50 per year. "MCO A" having a cap of 50 was an example provided in the webinar slides. Each MCO has a cap that is determined by an allocation formula that depends on other variables.

3. **Q: Does the CPI play a direct role in identifying and evaluating MCO partners?**

A: The CPI does not identify or evaluate MCO partners.

4. **Q: Are Case Management Agencies eligible to apply, or only Lead Health Homes serving children?**

A: Any organizations (including "Lead Health Homes serving children or Care Management Agencies") are welcome to apply if they meet the eligibility requirements specified in the RFP.

We are looking for 1 entity able to handle all of NYC (200 homes served in Year 1, 500 in year 2, and 500 in year 3). The entity should be a vendor of at least one MCO (including a signed business associate agreement and a completed vendor compliance process). If the Lead Health Home or Care Management Agency meets all the eligibility criteria, they can apply.