Delaware Health
And Social Services

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

PROCUREMENT

DATE: January 4, 2017

HSS –16-053

DDDS Targeted Case Management

For

Division for Developmental Disabilities Services

Date Due: January 17, 2017 @ 11:00 AM Local Time

ADDENDUM # 3

Addendum #3- Questions and Answers

The attached sheets hereby becomes part of the above mentioned RFP# HSS-16-053. All other terms and conditions remain the same.

Kieran Mohammed
Procurement Administrator

Marie Nonnenmacher
Deputy Director

RFP HSS-16-053
DDDS TARGET CASE MANAGEMENT
VENDOR QUESTIONS

VENDOR QUESTIONS	DDDS RESPONSE
CLIENT COUNTS	
How many individuals does this RFP cover? For example, the latest version of "The State of the States" published by the University of Colorado indicates that as of FY13 Delaware had 10,993 persons with IDD living with family caregivers, with an additional 2,565 living either in supervised living settings and either alone or with roommates; total of 14,558 persons. Does DDS anticipate that all or only an estimated percentage of this population would require TCM services? Accordingly, is there an available estimate of the percentage of the anticipated service population that is covered under Medicaid?	The number of individuals that DDDS projects will be served by the vendor-managed TCM is in a table on page 55 of the RFP. The table estimates the number of Medicaid eligible versus non-eligible individuals. This is based on individuals who have been determined to be eligible for DDDS services and projected growth for each segment of the population based on historical growth patterns.
Projected enrollment for TCM is shown in a table by TCM group. The Medicaid eligible for Lifespan waiver enrollment is as of 7/1/17. Wouldn't this be the beginning of SFY 2018? Should the box under # of persons SFY 2017 be blank?	Thank you for pointing out the error in the chart. The projections do begin with SFY17 as a point of reference, although the Lifespan waiver amendment will not be effective until 7/1/17 which, as a vendor correctly point out, is SFY18.
What are the numbers for each phase?	As of the September 2016 DDDS census report, there are 3,200 individuals who do not live in a provider-managed residential setting. These 3,200 people are the target group for the TCM vendor to manage. Of the 3,200 there are 1784 or 55% that live in NCC, 714 or 22% in KC and 735 or 23% live in SC.
What percent of the individuals requiring TCM are under the age of 21?	Of the 3,231 clients served by DDDS that are living in the family home, 1,197 or 37% are under the age of 21.

<table>
<tr><td>What is the number of people who will be served in each county, during each of the State Fiscal Years listed in the table in Section C of Appendix B?

Please provide county specific data relative to the number of persons in the targeted vendor TCM Groups.</td><td>DDDS expects the distribution of the population by county to remain relatively stable. Here is the distribution for the last 4 years as of June each year from the DDDS monthly census report.

<table>
<tr><td colspan="8">DDDS Monthly Census as of June 30</td></tr>
<tr><td colspan="8">By County</td></tr>
<tr><td>Year</td><td>NCC</td><td>%</td><td>KENT</td><td>%</td><td>SUSSEX</td><td>%</td><td>Total</td></tr>
<tr><td>2013</td><td>1450</td><td>56%</td><td>569</td><td>22%</td><td>591</td><td>23%</td><td>2,610</td></tr>
<tr><td>2014</td><td>1524</td><td>54%</td><td>614</td><td>22%</td><td>660</td><td>24%</td><td>2,798</td></tr>
<tr><td>2015</td><td>1652</td><td>55%</td><td>659</td><td>22%</td><td>703</td><td>23%</td><td>3,014</td></tr>
<tr><td>2016</td><td>1797</td><td>56%</td><td>700</td><td>22%</td><td>734</td><td>23%</td><td>3,231</td></tr>
</table>
</td></tr>
<tr><td>COMMUNITY NAVIGATORS</td><td></td></tr>
<tr><td>What is the basis in research or practice for the effectiveness of a caseload ratio of one Community Navigator to sixty individuals receiving services? Has DDDS consulted with NASDDDS or experts in other states about the reasonableness of the scope of services for Community Navigators having a caseload size of 1:60?</td><td>DDDS has selected a caseload ratio of 1:60 based on its experience contracting with individuals it calls Family Support Specialists to perform certain aspects of case management and within available funding. The caseload for those individuals is typically 1:100. The desired caseload ratio for the DDDS case managers that support individuals in a residential setting is 1:35. The caseload ratio for the Pathways to Employment program, a State Plan HBCS service that primarily supports individuals living in the family home, is 1:60. In determining an appropriate ratio, DDDS also sought the technical assistance from the National Association of State Directors of Developmental Disability Services (NASDDDS) to establish an acceptable caseload ratio that was “affordable”. That assistance included a review of materials from other states.</td></tr>
<tr><td>There are 3,229 people listed as the maximum number of persons to be served in SFY 2017. At a 1:60 ratio, the Vendor would need to hire 54 Community Navigators to</td><td>DDDS indicated in the instructions for the Budget Proposal that it assumes a ratio of 1 supervisor to every 10 case managers based on state practice but is willing to consider alternate proposals with</td></tr>
</table>

meet the caseload specifications. Does DDDS consider it reasonable to assume for every 10 Community Navigators at least one supervisor who meets the qualifications listed in the RFP will need to be hired?	justification.
Does DDDS currently screen its Family Support Specialists on the schedule that the RFP requires? If so, is the system electronic or manual? Is there a cost to the employee screening elements?	DDDS screens Family Support Specialist contractors against the Child and Adult Abuse Registries. All of the screening systems are electronic. There is no cost for the screening elements except the state and federal criminal background checks. These cost $52 per employee for the state check and $65 for the federal check.
Are any of the activities specified in the scope of work currently being performed by a vendor? If so, please identify the organization and the annual value of their contract.	Many of the activities specified in the scope are being performed by contracted Family Support Specialists who are paid an hourly rate for time worked. The primary activity that is not being performed under the Family Support Specialist contracts is assisting the family to develop a person-centered plan.
RFP Section IV-D-6 on page 22 states that "Until contract award, vendors shall not solicit any employees of the State, directly or indirectly, to leave the State's employ in order to accept employment with the vendor until contract award." However, Section IV-F on page 17 states that "it is the expectation of DDDS that the successful vendor interview and evaluate for hiring all current Family Support Specialists who are interest in serving in the role of Community Navigator as an employee of the vendor." These two statements seem to offset one another as we usually attempt to secure letters of commitment for future staff prior to award. Please clarify the States expectations.	Family Support Specialists are not employees of the state. They are contractors.

Statement of Work states, "The Community Navigator ensures the completion of the DE Support Needs Assessment Profile (SNAP), the Inventory for Client and Agency Planning (ICAP), or other assessment instrument as designated by DDDS..." Has the state identified other assessment tools that will be used? If so, please identify them.	Delaware currently uses a DDDS-developed risk assessment instrument to determine the level of risk of each individual immediately after they have been determined eligible for DDDS services. This assessment instrument assigns a risk score that groups DDDS eligibles into one of five risk categories. It is also currently used to prioritize entrance into the DDDS HCBS waiver. The ICAP to determine the maximum number of support hours of individuals who have left school. The SNAP is currently being piloted and is planned to be used to determine the maximum number of support hours (expressed as acuity levels) for individuals who select Shared Living as a residential option. DDDS may expand the use of the SNAP in the future for other DDDS consumers. Those are the two primary formalized assessment tools used by DDDS. However, there are other assessment tools that are used situationally, depending on the needs and challenges presented by individual DDDS consumers.
Is the DDDS standardized risk assessment instrument available electronically or is it paper based? Once completed, is the document housed in the ECR?	See response to question above. The DDDS standardized risk assessment has been programmed into the new electronic case record which is expected to be operational before July 2017.
Will the vendor be required to perform all activities specified in Section E.1, E.2 and E.4 during face-to-face meetings with the individual, or may some of the activities be performed telephonically?	The Community Navigators are required to conduct monitoring of the implementation of the person-centered plan at least monthly. While the vendor is encouraged to conduct face-to-face meetings with individuals they support as often as possible, the state only requires that one of the monitoring meetings (in addition to the annual planning meeting) must be a face to face meeting. Vendors may use other means to review the plan and to communicate with the individual and his or her family, including phone and email.

How much time does the selected vendor have to complete the initial person-centered plans (PCPs) for the enrolled individuals (e.g., within the first 30/60/90 days of contract start, etc.)?	This timeline can be negotiated with the successful vendor(s), but for the contract start up, vendors should generally assume that the initial plan will be finalized no later than 60 days from the date the consumer is referred to the TCM vendor.
What is the expectation for the process for those individuals who are within 30 days of their annual review at the time the contract is initiated?	None of the individual's covered under this contract currently has a person centered plan. The first plan will be developed by the vendor.
What are the minimum requirements/maximum allowances for face-to-face visits with the individual/family during any 12-month period?	There is no maximum number of face-to-face visits. The minimum number is two, one that occurs as the person centered plan is being developed or revised annually and one of the monthly monitoring events.
What is the timeframe required for responding to emergency situations? How is "responding" defined, i.e., personal visit, telephone contact, etc.?	The timeframe for response to emergency situations and the type of response must be proportionate to the type of emergency and the individual circumstances of the consumer. The response can include telephone or email interventions to ensure that the individual is healthy and safe and referrals to other entities, as appropriate. In true crisis situations, however, the Community Navigator may need to make an in-person assessment. DDDS resources can be made available to assist the vendor in some situations.
What type/nature of "participation" in reportable incident investigations will be required, i.e., face-to-face/telephone consultation with primary investigator, taking the role of primary investigator, answering background questions for primary investigator as needed?	Community Navigators are required to report suspected abuse or neglect as per the DDDS policy on reportable incidents. DDDS maintains a cadre of staff who investigate allegations of abuse or neglect. Community Navigators may need to be interviewed as part of these investigations. Community Navigators may also need to be involved in remediation strategies or monitoring of provider remediation activities as part of their monitoring responsibilities.
What are the most frequently spoken/understood languages by individuals/families that require TCM other than English?	Spanish and ASL are the most frequently used non-verbal English languages used by DDDS consumers.

Who will determine eligibility and what is the timeframe?	DDDS determines eligibility for DDDS services and will make referrals to the TCM vendor of individuals who are not living in a provider managed residential setting. Delaware Social Services (DSS) determines eligibility for Medicaid using software application called the ASSIST Worker Web. Individuals apply on-line. Once the system determines eligibility, the state sends a notice of the determination to the consumer or his or her family. Eligibility for regular (i.e. non-long term care) Medicaid only takes a few weeks. For individuals applying for long term care Medicaid, including the DDDS HCBS waiver, the application process usually takes about 2 months.
ELECTRONIC CASE RECORD (ECR)	
At what point in the implementation of Targeted Case Management in Delaware will the Vendor be able to use a fully-functional IT system (CX 360) vs. continuing to use the outmoded Therap system?	The Cx360 system is expected to be available to DDDS no later than July 2017.
Within the State's Electronic Case Record (ECR) or otherwise: (a) Can the State provide a link to the ECR for potential vendors to review in preparation of our proposal?	No. The "Delaware Cares" electronic case record system is undergoing User Acceptance Testing and is not currently available for view. As soon as the user acceptance testing had been completed and any necessary modifications have been made to the system, DDDS will provide access to the system. The current expected timeframe for this milestone is May 2017 which would be after the bid has already been awarded.
Will DDDS provide staff training on the electronic case record (ECR) system? If so, how many hours of training time will be required?	Yes – DDDS will provide training to a specified number of individuals for each provider, called System Administrators. It is then the responsibility of those individuals to train other employees who work for that provider, using a train-the-trainer model. In addition, DDDS will make training webinars available to provider staff as refresher or new worker resources. The System Administrator also has the ability to add, suspend or delete User accounts. The amount of training

	depends on the role of the User. The training for the DDDS case managers, which perform a similar role to that of the Community Navigators, is scheduled for 6 hours.
Are service authorizations transmitted to the successful vendor electronically? Via ECR?	That is how the new electronic case record system, Cx360, is designed to work. The go live date for that system will not occur until after the likely date of contract signing for TCM.
What means will be used to notify the successful vendor of individual referrals, i.e., electronically, by fax, etc.?	The details of the process will need to be developed but we expect that the referral will be made by assigning a DDDS consumer to the TCM vendor via the electronic case record.
Is the RMTS administered by a DDDS staff person or is it self-administered?	The RMTS is administered via a proprietary web-based software application. Each Community Navigator must participate in the RMTS.
Please explain the software that will be used.	DDDS has chosen to use proprietary software that DHSS has already competitively procured. This software is called AlloCap. It is licensed by the company, Public Consulting Group. DDDS will continue to use this software as long as they are contacted with department. The department may procure with a different vendor in the future. AlloCap is a Random Moment Time Study (RMTS) software that DDDS will use to separate Community Navigator activities into reimbursable and non-reimbursable categories. This data will be used for future TCM rate setting.
Because DDDS has chosen to use this software there will not be a need to incorporate any special or additional technology?	There is no requirement for the vendor to purchase specific software applications. However, the vendor and all of the Community Navigators will need to be able to access both the RMTS software and the Electronic Case Record software, both of which are web-based applications. The ECR software is called "Delaware Cares" and also "Cx360". It is developed by Core Solutions. Other divisions in DHSS are currently using a software application developed by this

	company. All providers delivering services under the DDDS HCBS waiver must be able to sign into this application. All access within the system will be role based. The vendor will also need to have the ability to send and receive secure encrypted email.
TCM STATE PLAN AMENDMENT (SPA)	
Has the State Plan Amendment been submitted or approved? Is there any assurance from CMS that it will be approved?	The State Plan Amendment was submitted to CMS on December 21, 2016 for an effective date of January 1, 2017.
With the change of administration, including a new HHS Secretary and CMS Director, does DDDS anticipate any delays in the approval of the Lifespan Waiver Amendment or the State Plan Amendment if it is not yet approved?	DDDS does not have any information indicating that the approval of either the TCM State Plan amendment or the Lifespan Waiver amendment will be delayed.
BUDGET	
Will start-up costs for the acquisition of laptops be available to the Vendor? Is there an existing inventory of laptops that could be transferred from DDDS to the Vendor?	Vendors may propose start-up costs as part of their budget proposal with supporting documentation. This will be negotiated with the successful bidder.
Has DDDS decided whether to use a model like Maryland's fee-for-service structure, with its inherent limitations, or is it willing to engage in rate development based on alternative national best practices (see below)?	DDDS has requested a monthly case management rate in its State Plan Amendment submitted to CMS. CMS generally does not like monthly rates but approved one for Washington state as recently as 2011. If CMS does not approve a monthly rate, DDDS will propose either a per diem or a 15 minute unit rate.
How is the unit rate determined? Will it be hourly, sub-hourly or a monthly unit rate?	DDDS has proposed a monthly rate in the State Plan Amendment. DDDS believes a monthly rate is the most comprehensive way to capture Targeted Case Management. However, it is unsure if CMS will approve a monthly rate. The vendor payment will have three conceptual pieces: 1) claims that are submitted by the vendor to Medicaid for Medicaid eligible individuals as the TCM service, 2) state

	payments for non-Medicaid reimbursable activities that are delivered to DDDS consumers and state payments for all activities for non-Medicaid eligible individuals.
How will you go from a budget to a rate?	The rate will use the negotiated vendor budget as the starting point to compute a unit cost rate. DDDS will use time study results to determine the proportion of time Community Navigators spend on Medicaid allowable activities. Because the vendor will not have completed an actual time study by the time the rate will need to be computed, a proxy will be used for the first year. This will be used as the numerator for the rate. Once we know what billable unit has been approved by CMS (month, day, 15 minutes), an assumption will need to be made of the number of units that will be billed. At the end of the rate year, a comparison will be made between the payments made using the rate and the actual allowable costs. Any difference will be applied to the rate for the next rate year as a "carry forward adjustment". This is a common practice in the development of indirect cost rates and is generally accepted by the federal government. This will be the denominator of the rate. Once a budget is negotiated, it will be the maximum payment that can be made to the vendor through a combination of claims made directly to Medicaid and payments the state will make. It is the vendor's responsibility to bill accurately. The state *will not* make up any differences in payment to the providers because they did not bill correctly.
The RFP states that "the negotiated budget will be used by DDDS to compute a unit cost rate that the Vendor will bill to the Medicaid Agency's fiscal agent under the Targeted Case Management State Plan option." The RFP, in the same paragraph, states that "DDDS will also pay the vendor a monthly amount at one twelfth (1/12) of a negotiated annual amount that covers the non-Medicaid	The vendor should submit a proposed budget identifying all costs necessary to meet all of the requirements in the RFP without regard to the source of payment. Based on the negotiated budget amount, the state will develop a fee-for-service rate for Targeted Case Management claims that the vendor will submit to Medicaid for each Medicaid eligible individual. DDDS will use State General Funds to pay the balance between the vendor's actual costs and the Medicaid

reimbursable costs." Appendix C, does not breakout costs for Medicaid eligible and non-Medicaid eligible individuals. How will the state compute the two different figures based on the one price submitted?	claimable amount up to the maximum of the negotiated annual budget. This balance to be paid with State General Funds includes activities that Medicaid will not pay for and DDDS consumers that are not eligible for Medicaid.
When proposing benefit costs, we typically apply our benefit rate to salaries rather than detailing it out by employee. Benefits can change yearly. The pricing sheet doesn't allow us to account for changes in benefit level. How would you like us to show this detail?	Please detail the benefits per employee even if the benefits are a formula applied as a percentage of the salary resulting in multiple individuals who do the same job having the same cost structure. Please complete the narrative description for each area, describing your approach to costing out each element, adding supplemental worksheets as necessary.
The pricing sheet computes a total program cost. Is this just for year 1 of the contract or the 2-year base period?	Please complete separate Budget Worksheets for each of the two initial years of the contract. Please label the worksheets clearly for each year as "Year 1" and "Year 2".
What is the expected FMAP for targeted case management?	Targeted case management is paid at the standard federal medical assistance percentage which is currently 54.20% for Delaware. It is computed using a formula that is specified in the Social Security Act. It is recalculated every year and it is published in the Federal Register usually in late November. The selected vendor(s) will receive payments from a combination of sources (including state and federal funds) that will cover agreed upon costs.
Given the anticipated size of the staff, including all the Community Navigators and Supervisors required to meet the caseload ratios specified, will the same assumptions for the allowable administrative percentage be used for Targeted Case Management as is being used for the DDDS DSP Rate?	Bidders should propose administrative costs as part of the Budget Proposal and should be explain and justify this expense for review and consideration by DDDS. DHSS considers 12% to be a reasonable administrative overhead percentage.
Are there any aspects of the Provider Specific TCM Manual that would influence the costs of the services that are not stated in the RFP?	The Provider Specific Manual will codify the approved SPA and will describe operational details of the TCM service that are more detailed than the SPA. It is doubtful that CMS would require Delaware to make changes to the SPA that would affect provider cost, but it is possible. If that happened, DDDS would provide that

<table>
<tr><td></td><td>information to all vendors that submitted proposals and allow them to make necessary changes.</td></tr>
<tr><td>Will a schedule of the current salaries of the Family Support Specialists be made available to applicants at least two weeks before the proposals are due?</td><td>Salaries for DDDS case managers and supervisors were provided in Budget Proposal instructions. Family Support Specialists are not employees of the state, so there are no salary figures to report. Please see chart below for expenditures for Family Support contracts.</td></tr>
<tr><td>Does the state have a budget ceiling or expected contract value for this program? If so, please provide that information.

Is there an allocation for this expenditure?</td><td>The contract budget will be negotiated with the selected vendor(s). Expenditures for the Family Support Specialist contracts for the past three years are shown below. Some of this funding will enable the state to draw a federal match.

<table><tr><th></th><th>FY14</th><th>FY15</th><th>FY16</th></tr><tr><td># of FTEs</td><td>36</td><td>35</td><td>53</td></tr><tr><td>Expenditures</td><td>$1.2M</td><td>$1.2M</td><td>$1.8M</td></tr><tr><td>cost/FTE</td><td>$33,465</td><td>$33,243</td><td>$33,748</td></tr></table></td></tr>
<tr><td>During a Governor's Advisory Committee (GAC) meeting back in March a DDDS presentation was given that showed current funding at approximately 1 million dollars which would be matched with federal funds. What is this current appropriated for?

What is the million dollars mentioned at the GAC funding?</td><td>DDDS currently spends state funds on both direct family support services, such as respite and personal care, and also on contracts for family support specialists. The funding DDDS is currently using for the family support specialist contracts will become the state match to enable us to draw federal funds to support targeted case management. Not all of the funding will be federally matchable.

During the presentation, one of the vendors present asked if the figure of $1.2 million that had been quoted in a series of recent presentations was what DDDS was currently spending for the Family Support Specialist contracts. The DDDS representative replied in the affirmative, but upon examination of the materials presented at those public meetings, it was discovered that the $1.2 million figure referred to in those presentations was the amount that DDDS was spending on direct family support services and not on the contracts</td></tr>
</table>

	with the Family Support Specialists. The chart above indicates how much DDDS has spent on contracts with Family Support Specialists since SFY14.
TCM provider work may be different depending if the rates will be a monthly model or the hourly model. What is the timeline for approval and knowing which will be used?	DDDS expects the TCM SPA to be approved by no later than March 31, 2017. DDDS has been informed by other states and NASDDDS, its professional association; it usually does not take a long time for CMS to approve a TCM SPA, as they are fairly common among the states. However, TCM is new in Delaware and has not been done at all. It will be a learning experience for all of us. This is one of the reasons why DDDS has weighted the experience level of the vendor so highly in the proposal rating criteria. DDDS is looking for an agency that is already familiar with targeted case management.
GENERAL RFP QUESTIONS	
What is the expected start date of this contract?	DDDS hopes to have a contract start date by April 2017.
Will there be an "implementation period" following contract award for the successful vendor to ramp up?	Section "C.2.d. Workplan" of the RFP requires the vendor to propose an implementation schedule for review and consideration by DDDS. The reasonableness of the implementation schedule will be included as part of the rating of the bids and changes to the proposal may ultimately be negotiated with the successful bidder.

What is the "go live" date by which the vendor would be required to begin program operations?	The vendor will be expected to commence operations under the contract immediately after contract effective date per the implementation timeframe that is agreed upon by the parties. The contractor must be capable of receiving referrals for TCM for members enrolled in the Medicaid Lifespan waiver by no later than July 1, 2017, which is the implementation date of the DDDS Lifespan waiver amendment. It is expected that referrals will be made in groups to facilitate smooth transition. Implementation schedules that result in the vendor being able to deliver case management earlier than July 1, 2017 will be favorably considered.
This scope of work includes a requirement to conduct an assessment to determine the individuals need for medical, educational, social, or other services. This is similar to the requirements specified in RFP #HHS-16-049 issued by the state on October 20, 2016. Please explain how the activities specified in these two RFPs are related.	RFP HSS-16-049 was issued to re-procure the administration of a proprietary client assessment process called the Inventory for Client and Agency Planning (ICAP). The ICAP is used by DDDS to determine the number of support hours that are required by individuals that are seeking residential or day services. This is one of many assessments DDDS uses in the conduct of its work.
The *deadline to respond* to Attachment 2: Non-Collusion Statement is January 13, 2016 at 1:00 P.M. (Local Time). Is this an incorrect date as this form needs to be included with our overall response, which is currently set to be due on January 17, 2017 at 11:00 PM (Local Time)?	Attachment 2: Non-Collusion Statement should be included with your overall response, which is due on January 17, by 11:00 AM Local Time.
Other than proof of State of Delaware Business Licensure, what other licenses and/or certifications are required for the Vendor to provide the services required under this RFP?	No other certifications are required in order for the vendor to submit a proposal under this RFP. The selected vendor(s) must be determined by DDDS to be a qualified provider of TCM services in order to enroll with the Medicaid agency as a Medicaid provider. DDDS will consider the signed contract to be validation that the provider meets the Medicaid enrollment criteria.

Should a Vendor's two paper copies and four electronic copies be complete versions containing confidential information? (b) Or, should confidential information be excluded from these copies and only put in a separate sealed enveloped (per the instructions on page 7)? (c) If excluded, is it acceptable for the Vendor to redact (i.e., black out) the confidential information in the two paper copies and four electronic copies to identify for the reader where confidential information has been excluded?	Per the instructions on page 7, confidential information should be submitted in a separate sealed envelope. Bidders cannot redact confidential information if they choose to include it in their paper copies or electronic copies.
The RFP appears to distinguish categories of subcontractors. (a) Will the State please explain what it considers to be a "major" subcontractor requiring identification versus another type of subcontractor which may not require identification? (b) Are major subcontractors considered a joint venture or are these two separate categories? (c) Are Vendors required to submit with their proposal copies of any type of subcontractor agreements?	List all subcontracts. There is no standard definition of major vs. minor. A joint venture is not equivalent to a subcontractor. However, a joint venture scenario should be disclosed. Copies of subcontracts are not required to be submitted in the RFP.
What is the process for obtaining the State's approval of sub-contractors and when does this process occur?	The proposed use of subcontractors will be discussed during the contract negotiation process.
If the RFP is silent on certain terms and conditions (i.e., there is nothing to take exception to), should a Vendor include supplemental or additional terms in its proposal for the State's consideration or may such supplemental or additional terms wait to be addressed in contract negotiations? If supplemental or additional terms should be included in a Vendor's proposal, where should such terms go in the proposal?	Any exceptions or additional terms should be noted on the Attachment 3- Exceptions Form. Additional pages may be submitted, but must follow the format provided.
Can the State provide clarification on their process and timeline for certification of Targeted Case Management	Signing the contract will constitute certification of the vendor as a qualified Medicaid provider of TCM.

providers?	
Will the State please provide more details such as examples of the milestones which will impact payments and the percentage of holdback the State intends to require?	DDDS does not intend to apply a holdback of contract funds to be paid as specified milestones are achieved. Once the annual budget and the implementation timeframe are negotiated, the contractor will be paid for actual costs incurred, less Medicaid allowable claims up to the annual contract maximum.
Does the State intend to include penalty provisions? If so, what areas will the provisions address and will such provisions be part of contract negotiations?	It is not DDDS's intention to include such penalty provisions.
1. Given the fact that all case management for people with intellectual and developmental disabilities in Delaware has been provided either by DDDS case managers or the Family Support Specialists under contract with DDDS, is it reasonable to assume that by specifying this experience requirement that DDDS has a preference for contracting with an out-of-state provider of case management services?	DDDS has expressed no preference for contracting with an out-of-state vendor to provide TCM. The RFP, however, is clear that the selected vendor(s) of TCM must not be a provider of any other HCBS service covered under the DDDS 1915(c) waiver, including services that will be added under the Lifespan amendment to the DDDS waiver that was recently published for public comment and is available for view on both the DMMA and DDDS websites.
2. If not, is this an area in which an organization might be able to "justify (an exception) to the requirements of the RFP which the applicant may have taken in presenting the proposal"? For example, would DDDS accept the experience of key personnel in awarding points for experience, such as a professional who directed a large case management agency, which is located in another state that has used independent service coordination since the mid-1990s?	The vendors should delineate their experience in delivering case management in their proposal. DDDS will consider all proposals that meet the minimum specifications and will rate them against the Proposed Selection Criteria.
The above RFP specifications for minimum requirements and general evaluation requirements do not identify a minimum number of years of vendor experience in providing case management services other than	The number of years of experience is not a minimum requirement in order to submit a proposal but will be used as a factor in rating the proposals.

"experience and reputation" will be evaluated. However, under Section C.2, Proposed Selection Criteria, item a. Familiarity and Experience, 3.a., third paragraph on page 13, on provider experience states: 3. Describe how the Vendor meets the following qualifications: a. A minimum of three (3) years of demonstrated experience providing case management services; Does the RFP specifically require all potential vendors to a minimum of three (3) years' experience in case management? Or, is this an item for evaluation that will be scored according to the level of case management experience of each potential vendor (regardless of number of years)?	
The State of Delaware may award a contract for a particular professional service to two or more vendors. Is it the Division's intention to award multiple contracts as a result of this procurement? If so, is there a minimum? A maximum?	Medicaid law allows states to limit providers of Targeted Case Management for individuals with intellectual disabilities. This is an exception to the regular Medicaid requirement for choice among qualified providers. DDDS believes, however, that being able to offer choice between two statewide providers of TCM would be of benefit to our consumers. We must temper that desire with the reality that Delaware is a small state, and it is more difficult to generate economies of scale necessary that would make this kind of business venture viable from a financial perspective.
Will this RFP result in an award to one or two contracted entities? If that is not yet determined, please indicate the factors that will be considered to decide if one or more entities are contracted for the work and the likelihood of a single or multiple awards? Does the Division have intent to award a single contract at this time?	See response to question above.

Would the State accept experience that is similar to case management services if it were provided to participants who have an intellectual disability?	DDDS will assess the experience and qualifications of the bidders based on the information submitted in the proposal.
Would the State consider extending the go-live date beyond the 60 days outlined in the RFP (i.e., more than 60 days from the effective date of the contract)? 60 days may not be an adequate period of time for the transition from the current contractor(s).	DDDS will consider allowing the selected vendor(s) to go live without being "fully operational". The terms of the implementation would be negotiated.
Do you expect the go live date to be July 1, 2017?	The July 1, 2017 is the maximum date to go live. Ideally everything should be in place by April. The hope is to have the contract signed no later than April 1, 2017. Referrals will be gradually sent. They will not come all at once but as people become eligible.
As of July 1, 2017 will the provider have the full complement of individuals?	We expect that there will be a large group initially, then two or three more large groups to follow. From that point on we expect the flow of new consumers to be at a steady rate.
Will programs be expected to have all staff hired and working by July 1?	This will need to be negotiated with the successful vendor(s). DDDS may be able work with the provider to provide some leeway, but the preference is for the provider to be fully operational by July 1st. CMS will have the expectation that the state is providing case management to the newly enrolled waiver members as of the effective date of the waiver amendment which is July 1, 2017. Your budget proposal for the first year should assume a full year. This will be negotiated based on the contract start date.
For the budget presentation can you give any guidance on how to represent the ramp up?	The work plan should describe any activities the vendor will need to undertake during start up. This includes activities such as hiring and training staff. From a budget perspective, the time frame is something that we will need to negotiate. It is assumed that the first year of the contract will include a more significant amount of "non-billable" time than subsequent years as the provider staffs up to provide the TCM service. The vendor's costs will still be covered by the state during this period before services can begin to be delivered.

	From a budget standpoint, the ramp up is not as critical, it will be handled similar to a cost reimbursement contract. You do not need to show any level of "partial funding" during ramp up in your budget calculation but you DO need to include the plan and timeline for the ramp up in your proposal from a programmatic perspective.
If the contract start date is July 1 could staff start work July 1st and then do training/orientation or would training be done prior to that start date of July1st?	Not all staff will get hired before the contract start date. Staff hired prior to the start date and those hired after should both be accommodated. DDDS does not expect staff to be hired or trained in DDDS specific requirements prior to the start of the contract, but obviously a vendor that has a readily available seasoned workforce that can start to deliver services more quickly after the contract start date would be viewed favorably during the rating of the proposals.
Will questions and answers asked today be available?	Yes, they will be put on the procurement website by January 3rd (this was amended to January 4th).
AGENCY WITH CHOICE BROKER – LIFESPAN WAIVER AMENDMENT SELF-DIRECTED OPTION	
Will the Agency with Choice provider vendor have the authority to terminate the employment of the attendant?	Yes, the AWC Broker is the employer of record and they have the authority to terminate the person as an employee. What is more likely to happen, however, is for the individual to decide that the caregiver isn't a good match for them and to request a different caregiver. Unless there are other reasons to terminate the worker for cause, the caregiver may continue to work for the agency for a different consumer.
Could there be a conflict of interest if the provider feels the employee is not meeting standards and should be let go and the individual still requests that individual?	Yes, that occurs now. Usually the state becomes involved in those cases to negotiate a positive result.
What is the role of the case manager as it relates to authorization/oversight/evaluation for personal care services through the Life Span Waiver?	The Community Navigator is responsible for explaining the available service array to consumers that have been referred to him or her, including the option for self-direction of the service called Community Living Support that includes personal care. If the person elects the self-direction option, the Community Navigator will refer

	them to the Agency with Choice Broker who will assist the consumer to hire and manage a caregiver. The Community Navigator will monitor the provision of the self-directed service and will function as part of the state's oversight of the Agency With Choice Broker. Community Living Support can also be delivered by traditional providers such as Home Health Agencies and Personal Attendant Service Agencies. The Community Navigator will assist the consumer to select a qualified provider and will monitor the delivery of the service.
Agency with Choice vendor will rely on the targeted case manager to report back quality of service?	Yes, the Community Navigator is responsible for making sure the person centered plan is being followed and that the services are delivered according to the plan. Even though the Agency with Choice Broker is administering the self-directed Community Living Support service, the Navigator still has general oversight responsibility for all services received by the individual.