Delaware Health
And Social Services

DIVISION OF MANAGEMENT SERVICES

PROCUREMENT

DATE: October 22, 2010

HSS-10-091

Non-Emergency Medical Transportation Services

for

Division of Medicaid & Medical Assistance

Date Due: November 30, 2010
By 11:00 A.M.

ADDENDUM # 2
Q&A and Revised RFP Pages
Appendix K Procurement Schedule – NOTE REVISED DUE DATE
Appendix F Number 14

PLEASE NOTE:

THE ATTACHED SHEETS HEREBY BECOME A PART OF THE ABOVE MENTIONED RFP.

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APPENDIX K
Revised 10/22/2010

Procurement Schedule

The Department's proposed schedule for reviewing proposals is indicted below. The Department, in all cases, will determine the ultimate timing of events related to this procurement.

EVENT	DATE
RFP advertisement and issuance	September 16, 2010
Mandatory Pre-bid Meeting	October 5, 2010 @ 10:00 a.m. 1901 N. DuPont Highway Main Building, Room #198 Sullivan Street New Castle, DE 19720
Questions must be received in writing no later than:	October 11, 2010 @ 12:00 p.m.
Response to Questions	October 22, 2010
Bid Opening	November 30, 2010 @ 11:00 a.m.

Bids will be publicly opened at the Procurement Branch, Main Administration Building, 2nd floor, on: **November 30, 2010 @ 11:00 a.m.**

Selection Process	December 1 – December 15, 2010
Issue Award Notices	December 16, 2010
Negotiations (if necessary)	December 20 – December 22, 2010
DTI Review	December 22, 2010 – January 19, 2011
Sign Contract	January 19, 2011
Readiness Review	March 14 – 16, 2011
Estimated Contract Start Date	April 1, 2011

APPENDIX F
Revised 10/22/10

Medical Assistance Coverage Groups

In Delaware, the following groups are eligible for Medical Assistance:

1. Pregnant women and infants whose family income does not exceed 200% of the FPL for the family size. Pregnant women count as two persons. For pregnant teens, one half of parents' income is not counted. There is no resource test.

2. Children age 1 through age 5 whose family income does not exceed 133% of the FPL for the family size. There is no resource test.

3. Children age 6 through age 18 whose family income does not exceed 100% of the FPL for the family size.

4. Children in families with income that does not exceed 200% of the FPL may be eligible for the Delaware Healthy Children Program, our SCHIP program. Under the Delaware Healthy Children Program, the child cannot have other insurance. There is no resource test. They are not eligible for transportation services.

5. Uninsured adults between ages 19 and 65 whose income does not exceed 100% of the FPL for the family size. They cannot have Medicare or other comprehensive health care coverage. They must enroll with a managed care plan before coverage begins. There is no resource test.

6. Low income families with children eligible under Section 1931 and certain children living with stepparents, grandparents, siblings, or alien sponsors whose family income does not exceed 75% of the FPL for the family size. There is no resource test.

7. Families who were receiving Section 1931 Medicaid but start to work or start to receive child or spousal support receive extended Medicaid ranging from 4 - 24 months.

8. Needy children in foster care placement or subsidized adoption.

9. Individuals who receive Supplementary Security Income (SSI) or a State Supplementary Payment.

10. Some individuals who have lost SSI are eligible for certain SSI related Medicaid programs.

11. People who need long term care services in a nursing home or at home; or severely disabled children through age 18 and whose income does not exceed 250% of the SSI payment standard. Resource limit is $2,000.00. For severely disabled children; parents' income is not counted.

12. Low income Medicare beneficiaries (QMBs) whose income does not exceed 100% of the FPL are eligible for payment of their Medicare premiums, coinsurance and deductibles by Medicaid. Certain

Medicare recipients (SLMBs and Qualifying Individuals-1) whose income does not exceed 135% of the FPL are eligible for payment of Medicare Part B premiums only. These groups are not eligible for transportation services.

13. Uninsured women under age 65 who are not eligible for a mandatory Medicaid group and who need treatment for breast or cervical cancer. There is no income or resource test.

14. Certain Non-citizens (aliens) are eligible for emergency medical care and labor/delivery services only. They are eligible for transportation to emergency services only which includes labor and delivery.

15. Women of childbearing age who lose Medicaid for non-fraudulent reasons are eligible for family planning services only for up to 24 months. They are only eligible for transportation services to a family planning service.

16. Medicaid for Workers with Disabilities

17. Birth to Three Program

18. Chronic Renal Disease Program Clients

REVISED RFP PAGES

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1.18 ON-TIME PERFORMANCE (revised 10/21/10)

The Contractor shall have procedures in place to ensure that vehicle availability is adequate to fulfill standards of promptness. ~~No more than one-half of one percent (0.5%) of the trips should be late or missed in each region per day.~~ No more than four percent (4%) of trips should be late or missed per month.

The Offeror shall provide complete information on the Offeror's transportation capacity (number and types of vehicles in each city or county) as of the date of submission of this RFP, and planned capacity as of the anticipated start date of the contract with DMMA. The description shall also include contingency plans for unexpected peak transportation demands and back-up plans when notified that a vehicle is excessively late or is otherwise unavailable for service.

1.19 INSUFFICIENT RESOURCES FOR ACCESS

The Contractor must demonstrate that the transportation provider network provides adequate access in each county in the state, based on the number of recipients and the number of trips provided. If the Contractor or DMMA identifies insufficient transportation resources in a region, the Contractor shall develop and implement a provider recruitment plan to develop sufficient resources to meet the transportation needs of Medicaid recipients in the geographical areas covered within 10 days.

1.20 PROVIDER LIST

The Contractor must provide a current list of its provider network to DMMA quarterly with additions and terminations of providers listed with the reason for each termination.

1.21 PENALTIES

If the Contractor fails to comply with any of the aforementioned requirements set forth in this section, DMMA may apply financial penalties against the monthly payment from DMMA up to $1,000.00 per incident.

1.22 CURRENT NET PROGRAM

The current NET program is a result of a Request for Proposal (RFP) dated October 2002 and was developed as part of a cost containment measure and to increase efficiency. NET services are defined in the RFP as necessary non-emergency transportation services provided to DMAP clients to ensure reasonable access to and from medical services. Necessary transportation is defined as the least expensive mode of transportation available that is appropriate to the medical and or functional needs of the client. DMMA seeks to contract with one broker to be responsible for the administration and provision of NET transportation in each of the three counties in Delaware to include wheelchair van, non-emergency ambulance, public transportation and car/station wagon, mini van services and mileage reimbursement. Non-emergency

a. Services which are not medically necessary
b. Vaccines required for travel outside the United States
c. Cosmetic surgical procedures and treatment
d. Procedures (other than those transplants covered by transplant criteria) designated as experimental by the Medicare program
e. Services denied by Medicare as not medically necessary
f. Dental services for individuals 21 years and over
g. Routine eye care and/or corrective lenses (except aphakic or bandage lenses necessary after cataract surgery) for individuals 21 years and over
h. Hearing aids for individuals 21 years and over
i. Social services
j. Podiatric services. Routine foot care is only covered for clients who are diagnosed as having diabetes or circulatory/vascular disorders
k. Chiropractic Services

1.13 DETERMINATION AND VERIFICATION OF ELIGIBILITY

The Division of Medicaid and Medical Assistance establishes eligibility criteria for clients of medical assistance coverage based on federal regulations. The Division of Medicaid and Medical Assistance and the Division of Social Services in the Department of Health and Social Services determine eligibility for DMAP. See Appendix F for a description of the eligibility groups. The Broker must protect the confidentiality of the DMMA client.

1.14 ELIGIBILITY VERIFICATION SYSTEM (EVS)

Currently, providers have the option to access DMAP client eligibility information through:

a. Web based provider interface;
b. Point-of-Sale (POS) device;
c. Provider Electronic Solution (PES is free software distributed to providers for billing and eligibility verification); and
d. Voice Response System (VRS is available 24 hours each day for providers with touch tone phones)

Each option listed above provides eligibility verification for DMAP clients. All options, except POS, offer additional information such as restrictions, Managed Care Organization (MCO) participation, and third party insurance coverage information. PES software also offers the ability to verify eligibility for multiple clients in one transmission.

In addition to the EVS options listed above, Delaware's Medicaid Management Information System (MMIS) also accepts the Health Insurance Portability and Accountability Act (HIPAA) compliant 270 Eligibility Inquiry transaction and provides the resulting 271 Eligibility Response transaction.

2.20 LEVELS OF TRANSPORTATION (revised 10/21/10)

When determining the most appropriate mode of transportation for a client, a basic consideration must be the client's current level of mobility and functional independence. Modes other than public transportation must be used when the client:

a. is able to travel independently but, due to a permanent or temporary debilitating physical or mental condition, cannot use the mass transit system; or
b. is unable to be accommodated by the public ~~paratransit~~ transportation system; or
c. is traveling to and from a location which is inaccessible by mass transit (accessibility is not within 1/4 mile or three (3) blocks of scheduled stop).

The Broker shall determine the most appropriate mode of transportation needed by the client based on information provided by the client.

2.21 MODES OF TRANSPORTATION

Transportation services to be provided under this contract include the following:

a. **Mini Van/Car:** A multiple passenger van or vehicle. Commercial taxi service may be considered a component of this mode of transportation service.
b. **Wheelchair Van:** A van equipped with lifts and locking devices to secure a wheelchair safely while the van is in motion.
c. **Public transportation:** Brokers are encouraged to use federally-funded and public transportation whenever possible if it is cost-effective to do so.
d. **Station wagon**: a multiple passenger vehicle.
e. **Non-emergency ground ambulance**: an ambulance equipped per State regulations.
f. **Mileage Reimbursement/Volunteer**: provide reimbursement for mileage
g. **Train/Subway**: Brokers are encouraged, when available, to use trains and subway systems whenever possible.

Public transit - The broker must not utilize public transit for the following situations:

a. High-risk pregnancy,
b. Pregnancy after the eighth month
c. High risk cardiac conditions
d. Severe breathing problems, and
e. More than three block walk to the bus stop.
f. Client traveling with two (2) or more children under the age of six (6)

4.01 Audited Financial Statements (revised 10/21/10)

~~Audited financial statements or equivalent information for the applicable legal entity (Offeror) must be provided for each of the last two appropriate fiscal years. Such statements or equivalent information shall be specifically related to the Offers provision of non-emergency transportation services.~~

For the duration of the contract period the Broker must submit an annual certified financial audit through the close of each State fiscal year, calendar year or tax reporting year within six (6) months of the close the year's end. The Broker will inform DMMA of the Broker's choice of reporting year within thirty (30) calendar days of Contract execution. Audits are to be completed in accordance with Generally Accepted Accounting Principles (GAAP). Audits must be certified by an independent Certified Public Account (CPA). The audit shall include, but may not be limited to, the Balance Sheet, Income Statement, Statement of Retained Earnings, Statement of Cash Flow, notes thereto and the Auditor's Opinion thereon. The Broker will provide a copy of the management letter issued by the audit firm or verification from the audit firm that no such letter was issued. The annual audited financial statements must be submitted for the entity with which the State is contracting. If the Broker is part of larger organization, the annual financial statement of the larger organization must also be submitted with clear explanation of the financial connections between the Broker and the larger organization.

4.02 Budget narrative.

The budget narrative is intended to more fully explain items and costs associated with the Budget Schedules you complete for this project proposal. The narrative should supply a clear, concise, and accurate narrative. Some of the general topics that should be addressed include, but are not limited to:

- Budget items based on projections and/or assumptions that may need justification. Describe the basis for cost calculations and any rationale that may serve to support the process used.
- Provide any information that may help reviewers understand items in the budget. Particularly, how the capitation rate was developed based on the information provided in the budget schedules and program data on clients in the eligible population.

4.03 Additional Statement

The Offeror shall provide a statement that attests that no sanction, penalty or compliance action has been imposed on the resultant Contractor within the three years immediately preceding the date of the Offerors response to this RFP that could jeopardize the resultant Contractor’s ability to fulfill all contract requirements.

4.04 Payment

recipient. Drivers are to remain at or near their vehicles and are not to enter any buildings.
DMAP Delaware Medical Assistance Program
DMMA Delaware Medicaid and Medical Assistance
Door-to-Door Service is provided to passengers who need assistance to safely move between the door of the vehicle and the door of the passenger's pick-up point or destination. The driver exits the vehicle and assists the passenger from the door of the pick-up point (e.g., residence), escorts the passenger to the door of the vehicle and assists the passenger in entering the vehicle. The driver is responsible for assisting the recipient throughout the trip. Drivers, except for ambulance personnel, are not allowed to enter a residence. ~~In order to receive door-to-door service, the recipient must submit a medical certification statement from their physician. The certification must document that the recipient has a physical, sensory, mental, developmental or cognitive disability that requires door-to-door assistance to be provided for the safe transport of the recipient.~~
~~Physical disability to a degree that personal assistance is necessary~~
Exceptional Out-of-State Transportation is non-emergency transportation to a site outside of Delaware's borders so that a recipient can receive health care treatment that is not normally provided through in-state health care providers. Examples include sending individuals with rare diseases to a nationally known treatment center, or using new treatment procedures that only a few specialists in the United States are able to provide. All exceptional out-of-state transportation services are arranged and pre-approved through DMMA. These services are not in the scope of the Contractor's responsibility. DMMA assumes responsibility for the cost of these trips.
Freedom of choice: With certain exceptions, a State's Medicaid plan must allow recipients to have freedom of choice among health care providers participating in Medicaid. The broker should accommodate requests for a specific provider when able, especially in the transportation of recipients with disabilities. Transportation outside the area customarily used for health care services by the recipient's immediate community is to be provided only when sufficient medical resources are not available in the area or when a health care provider has referred the recipient to health care services outside of the immediate community.
Gatekeeping: Verify client eligibility, assess member need for NET services, determine the most appropriate transportation method to meet the clients need, educate clients in use of transportation service.
Grievance (Recipient): A verbal or written expression of dissatisfaction from the recipient. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, condition of mode of transportation, aspects of interpersonal relationships such as rudeness of a provider or employee.
Grievance (Provider): A written request for further review of a provider's complaint that remains unresolved after completion of the complaint process.
Late is defined as more than 15 minutes after the scheduled pick-up time.