RFA #17682 / Grants Gateway # DOH01-CSP1-2018

New York State Department of Health
Center for Community Health/Division of Chronic Disease Prevention
Bureau of Cancer Prevention and Control

Breast, Cervical and Colorectal Cancer Services Program (CSP)

Modifications, Questions and Answers
2/26/2018

MODIFICATIONS

The following has been updated/modified in the RFA. Strike-through indicates deleted text; underlined/bolded text is new.

II. Who May Apply, B. Preferred Eligibility

1. Are health care systems, hospitals or primary care networks **(including their foundations)**.

V. Completing the Application, A. Application Format/Content, 2. Program Specific Questions, e. Technical Proposal

v. Describe the comprehensive provider network that will offer screening and diagnostic services throughout the service region; how does the plan ensure sufficient numbers and types of providers to meet CSP-eligible client needs throughout the service region. Describe how you will engage, communicate with and make changes to providers. Include Letters from Clinical Service Providers dated within 30 days of the application due date and other documents demonstrating sufficient numbers and types of providers throughout the service region as Attachment 14. Scan these into one document no larger than 10MB and upload to the Pre-Submissions Upload application section. Letters should include the provider contributions (e.g., type of services offered, where located, how data-sharing and client follow-up is done, type of population seen) and should not be form letters or state general application support (these will not be considered and may result in lower scores)**. The letters from each clinical provider may not exceed two, double-spaced pages; any individual letters beyond that will not be reviewed.**

Attachment 11: Grants Gateway CSP Work Plan Instructions
Prescribed Performance Measure Names and Narratives

Objective 3, Targeted Outreach (page 4):

The Task 2 Performance Measure Name and Narrative provided in Attachment 11 should be entered for Objective 3, **Task 3** in the Grants Gateway, Work Plan. Task #2 does not require entry of a Performance Measure.

Objective 4, Provision of Health Services: Screening, Diagnostic and Case Management Activities (page 4):

Task 1, Performance Measure 3 Name**:** Clinical Service Provision

Narrative: ≥ 75% of screening mammogram clients age 50 and older, ≥ 20% of initial program-funded pap tests for women rarely or never screened for cervical cancer, ≥ 20% of clients who are male, ≥ 75% of clients are age 50 to 64, ≥50% of women age 50 and older with comprehensive screening**.**, ~~≥15% of eligible population screened in each county.~~

QUESTIONS AND ANSWERS

Service Regions, Available Funding and Anticipated (Number of) Awards

Q1: What is the state's goal in terms of a multi-county approach on this grant?

A1: The short-term, intermediate, and long-term outcomes of the Breast, Cervical and Colorectal Cancer Services Program (CSP) are listed on RFA p. 10. The long-term outcomes are to reduce breast and colorectal cancer morbidity and mortality and reduce disparities in breast, cervical and colorectal cancer incidence and mortality. To achieve these goals, successful awardees (CSP contractors) will conduct activities to provide free breast, cervical and colorectal cancer screening and diagnostic follow-up services to uninsured and underinsured women and men who are at or below 250% of Federal Poverty Level and meet other eligibility requirements, with an emphasis on those who are disproportionately burdened by an increased risk of cancer and/or who are medically unserved or underserved. While the number of contracts awarded through this RFA are less than the current number of CSP contractors, awards made as a result of this RFA will ensure statewide coverage so that every New York State (NYS) county and New York City (NYC) borough is covered by a CSP contractor. The number of men and women eligible for and provided services by the CSP has decreased over the past five years with implementation of the Patient Protection and Affordable Care Act as more CSP-eligible clients are covered for these screening services through Medicaid or a Qualified Health Plan. This has led to fewer CSP-eligible clients in some areas of the state, necessitating the reduction in the number of contracts and changes in service regions to align with eligible populations and preserve available funding for provision of cancer screening and diagnostic services to the remaining CSP-eligible clients. The 22 new CSP contractors will still cover the entire state – every county and borough will be served by a CSP contractor. This model allows for statewide

coverage while also creating administrative efficiencies and allocating available funding to reimbursement for cancer screening and follow-up diagnostic services for the remaining eligible populations.

Q2: I am still not sure if you are looking to expand the overall number of sites, or is this basically the renewal process for existing sites?

A2: This is not an expansion of the current number of sites. This is a competitive application opportunity to make awards for CSP contracts for a new, five-year grant period. There are currently 35 CSP contractors whose contracts end September 30, 2018. This RFA will reduce the number of CSP contractors from 35 to 22 with the new five-year period anticipated to begin October 1, 2018.

Q3: As an applicant for the RFA #17682 Breast, Cervical and Colorectal Cancer Services Program (CSP), there have been two contractors serving the six counties within CSP Service Region 11 for the past 11 years. Is it expected that Service Region 11 will continue to be split between two contractors, or will one contractor be expected to serve the entire, 6-county region?

A3: There will not be two contractors for Service Region 11 in the new CSP grant period anticipated to begin October 1, 2018. Awards will be made to one successful applicant per service region. Applicants are encouraged to collaborate with the existing CSP contractors through subcontracts or other partner arrangements to implement required activities throughout the entire service region. Applicants proposing such collaborations may be awarded preference points. (RFA pp. 8, 42 and 43)

Q4: Additionally, if the Service Region will be split, what can each contractor expect its potential maximum award to be?

A4: The service regions will not be split, there will only be one contract per service region (see Attachment 1, CSP Service Regions.) The 12-month State infrastructure contract values for each service region are listed in Attachment 2, CSP Service Regions and State Infrastructure Contract Values. These infrastructure values are based on the anticipated costs for provision of required activities throughout the entire service region and the estimated number of CSP-eligible uninsured women ages 40 to 64 and men ages 50 to 64 in each region.

Q5: How were service regions chosen? Although most look like they follow DSRIP (Delivery System Reform Incentive Payment Program) regions, the Western 1 Region does not follow DSRIP region, nor does it take into account health care regionalization that is taking place across NYS, particularly in this area of the state.

A5: Service regions were created based on many factors, including the estimated CSP-eligible populations within each region, practice patterns, and available services. The number of men and women eligible for and provided services by the CSP has decreased over the past five years with implementation of the Patient Protection and Affordable Care Act as more CSP-eligible clients are covered for these screening services through Medicaid or a Qualified Health Plan. This has led to fewer CSP-eligible clients in some areas of the state, necessitating the reduction

in the number of contracts and changes in service regions to align with and preserve available funding for provision of cancer screening and diagnostic services to eligible clients. The 22 awarded contractors will still cover the entire state – every county and borough will be served by a CSP contractor. This model allows for statewide coverage while also creating administrative efficiencies and allocating available funding to reimbursement for cancer screening and follow-up diagnostic services for the remaining eligible populations.

Q6: Please go over how much an organization will qualify for? How do we arrive at this amount?

A6: The maximum annual (12-month) values of the State infrastructure contracts for each of the 22 service regions are listed on Attachment 2, CSP Service Regions and State Infrastructure Contract Values, in the last column titled, "Annual Infrastructure Contract Value $". Applicants should prepare 12-month budgets that total but do not exceed these annual infrastructure contract values for their application service region (RFA, p. 40).

Q7: RFA p. 6, I Introduction, D. Available Funding and Anticipated Awards, 3. Available Funding: Is there the availability to increase infrastructure funding to pay for the increased need for additional key staffing positions due to the increase in the service region and the fact that CSP expenses are not reimbursable through Article 6 funding (local health department funding through the New York State Department of Health)?

A7: Applicant's should prepare 12-month budgets that total but do not exceed the annual infrastructure contract values for their application service region as listed in Attachment 2, CSP Service Regions and State Infrastructure Contract Values. These infrastructure values were based on anticipated costs needed to provide required activities throughout the entire service region, the estimated number of eligible uninsured women ages 40 to 64 and men ages 50 to 64 in each region, and available funding.

Q8: Our current 3-county CSP service region has been changed and is combined with another current 3-county CSP service region into one, 6-county service region. If my agency writes the new grant application, how do we get reimbursement from the other current CSP for their share of the grant-writing?

A8: Grant-writing and other costs related to preparing the application in response to this RFA are not allowable budgeted expenses on grant contracts awarded as a result of this RFA, nor are they allowable budgeted expenses on the currently funded State CSP contracts. Therefore, the State cannot comment on applicant agency costs related to application preparation and submission.

Q9: How will the funding for the new service region be allocated to each of the current two CSP contractors, will the funding be split 50/50?

A9: The annual (12-month) values of the State infrastructure contracts for each of the 22 service regions are listed on Attachment 2, CSP Service Regions and State Infrastructure Contract Values, in the last column titled, "Annual Infrastructure Contract Value $". Application

budgets should total but not exceed the value for their application service region. Existing CSP contractors are encouraged to collaborate on development of applications for implementation of the CSP within their service regions and should determine how to support collaborators, for example, through proposed subcontracts or other agreements. Applicants that demonstrate such collaborations may be awarded preference points.

Q10: Will the structure remain the same as it is now? When there are currently two CSPs covering regions that will now be merged into one service region, who will employ the current staff in the other region? Will our agency employ them because we hold the grant? Or, will positions be eliminated and only one CSP will oversee all six (6) counties?

A10: There will only be one CSP contractor serving the new, six-county region. The structure of the new CSP will be dependent on the successful application for that service region. Existing CSP contractors are encouraged to collaborate on development of applications for implementation of the CSP within their service regions and should determine how to support collaborators, for example, through proposed subcontracts or other agreements. Applicants that demonstrate such collaborations may be awarded preference points.

Q11: Which CSP is responsible for gathering and submitting information to grant writers in a service region in which there are currently two CSPs, but in which there will now be one CSP?

A11: Existing CSP contractors are encouraged to collaborate on development of applications for implementation of the CSP within their service regions and should determine how to support collaborators, for example, through proposed subcontracts or other agreements. Applicants that demonstrate such collaborations may be awarded preference points.

Current Contractor Lists and Information

Q12: Can you tell me what organization is currently funded to operate the Cancer Services Program in the Bronx?

A12: Lincoln Medical and Mental Health Center is the contract organization for the CSP of the Bronx. Contact information is available on the Department of Health website at, https://www.health.ny.gov/diseases/cancer/services/community_resources/, listed by County. You may also send an email to canserv@health.ny.gov with requests for this information.

Q13: How can applicants acquire the list of providers and collaborative partners for the current CSP programs in the counties we don't currently run and are in the region we propose to cover? (Section B, #4 Provision of Health Services, a.i., a.ii., pg 15)

A13: Applicants are encouraged to contact the current CSP contractors for their application service regions. Contact information is available on the Department of Health website at, https://www.health.ny.gov/diseases/cancer/services/community_resources/, listed by County. You may also send an email to canserv@health.ny.gov with requests for this information.

Eligible Applicants

Q14: For the CSP grant announcement (RFA #17682), I just want to clarify if the RFA is intended only for already existing CSP programs?

A14: All organizations meeting the minimum eligibility criteria as stated on RFA p. 7 are eligible to apply to this funding opportunity. Applicants to this RFA are not limited to existing Breast, Cervical and Colorectal Cancer Services Program (CSP) contractors.

Q15: Are these grants available only to existing CSP screening partners?

A15: No. This funding opportunity is available to any organization meeting the eligibility requirements as stated on RFA p. 7.

Q16: We are currently funded through the New York State Department of Health/Health Research, Inc. (NYSDOH/HRI) Patient Navigation in New York State Nationally Accredited Programs for Breast Centers (PN NAPBC) contract and a facility (participating provider) under CSP contracts. Would we be eligible to submit this grant application or is "doubling down" not an option?

A16: All organizations meeting the minimum eligibility requirements as stated on RFA p. 7 are eligible to apply to this RFA. If awarded, your organization will be awarded the CSP contract, which is separate from the PN NAPBC HRI contract. Note that supplanting is not allowable and your organization, if awarded the CSP contract will be responsible for implementing all requirements of both contracts. (See responses to questions 17, 44, 48 and 72.)

Q17: How does this affect the NYS Patient navigation grant created by Governor Cuomo?

A17: This is an additional, separate funding opportunity than the PN NAPBC contracts created by Governor Cuomo in 2016. This RFA will award up to 22 contracts to implement the Breast, Cervical and Colorectal Services Program (CSP). The CSP contractors will offer free breast, cervical and colorectal cancer screening to uninsured and underinsured, eligible women and men with a focus on those that are disproportionately burdened by an increased risk of cancer or are medically unserved or underserved. The CSPs will also implement patient navigation within health care systems to increase breast, cervical and colorectal cancer screening among the patient populations. This is a different program and grant than the Breast Programs Governor Cuomo created in 2016, one of which is the PN NAPBC. In 2016, 33 NAPBCs received funding for up to three years to implement patient navigation to assist women in their communities with receipt of breast cancer screening. CSP contractors are also required to implement patient navigation, but, the CSP patient navigation efforts will improve breast, cervical and colorectal cancer screening among patient populations in health care systems. The applicants to this CSP RFA are encouraged to collaborate with the PN NAPBCs and other programs funded as part of the Governor's Breast Programs to offer and provide free breast, cervical and colorectal cancer screening services to CSP-eligible clients. To receive a list of these contractors, email a request to: canserv@health.ny.gov using the subject line, "RFA 17862, DOH01-CSP1-2018-Contractor List". (See RFA, pp. 3, 8, 14, 42)

Q18: Can the health system's foundation (a 501c3) be the applicant on behalf of the hospitals/health system? Would this earn extra points as well?

A18: Yes, the health system's 501c3 foundation is eligible to apply on behalf of the hospital/health system. Refer to the modification to RFA Section II. Who May Apply, B. Preferred Eligibility at the beginning of this document for clarification.

Q19: We are looking to be the subcontractor for a partner on this. Also, is it possible for us both to apply for the service region and list each other as subcontractors? I understand only one award will be awarded per region.

A19: All organizations meeting the minimum eligibility requirements as stated on RFA p. 7 are eligible to apply to this RFA. Collaborations through subcontracts and other partnering activities are encouraged to facilitate provision of services and the full scope of work to the CSP-eligible and priority populations throughout the entire service region. Since, as you note, only one award will be made within each service region, your application will compete for the one award for your service region. We encourage you and the other organization with whom you will partner to discuss which of your two organizations is best suited to hold the contract, employ the Program Coordinator and meet all other RFA requirements. You may also want to consider which of your organizations is most likely to garner preference points (see RFA pp. 8, 42, and 43) and therefore, should submit the application for that service region.

CSP-eligible Clients/Client Eligibility

Q20: What do you consider underinsured?

A20: A client is underinsured if s/he has health insurance that does not cover clinically appropriate cancer screening or diagnostic services, or, health insurance with an annual deductible, monthly spend down, or copayment high enough to prevent him/her from obtaining cancer screening and/or diagnostic services. Refer to the CSP Operations Manual, Chapter 3, Section C. Eligibility Criteria Definitions for additional information. To request a copy of the CSP Operations Manual, send an email to: canserv@health.ny.gov, with the following subject line, "RFA #17862, DOH01-CSP1-2018 Operations Manual".

Q21: Please go over the eligible client criteria? We have a very well insured community in East Brooklyn. However, our rates of cancer are extremely high, which means that we have a desperate need for education and screening. Please address how we would qualify?

A21: CSP client criteria or eligibility for receipt of free breast, cervical and colorectal cancer screening and diagnostic services is based on client health insurance status, income, age and other personal criteria such as risk status. CSP-eligible clients include individuals who are uninsured or underinsured, whose household incomes are at or below 250% of Federal Poverty Guidelines, women ages 40 and older, and men ages 50 and older. For a full list of CSP-eligibility criteria, see RFA pp. 8 and 9. The required CSP work of patient navigation and implementation of evidence-based interventions within health care systems is not limited to CSP-eligible clients (not limited to uninsured and underinsured) but should focus on identified priority

populations. The population you describe may be an appropriate priority population for the patient navigation work, but not for CSP screening services, nor for the full required scope of work of the CSPs awarded contracts through this RFA. Your organization may otherwise qualify to apply, but, must implement all required activities throughout the entire service region. You are encouraged to contact the existing CSP in your service region to discuss the potential for partnering and collaboration for your population and to email canserv@health.ny.gov to request a contractor list to learn about additional programs in your area that may be of benefit to the population you serve.

Screening and Diagnostic Services Providers/Provider Agreements and Credentialing

Q22: In terms of provider contracts, will we need new contracts for the 2018-2023 grant cycle and will each county have their own contracts with existing providers or will they need to expand their contracts to cover each county they are paired with (each county within their service region)?

A22: CSP contractors will obtain written agreements with all health care providers and clinical laboratories that offer screening and diagnostic services to CSP-eligible clients (participating providers) throughout their entire service region for the new, five-year grant period. The NYSDOH will provide a required "Provider Agreement" which will include the Participating Provider Requirements in the Master Grant Contract Program Specific Clauses. A-1, Part B. You can access the Master Grant Contract document within the Forms Menu of your application. Click on *Contract Document Properties*, then *view file* under Attachment A-1 Provider agreements must be signed by the contractor, participating provider and the NYSDOH designee and will be established for the duration of the five-year grant period and updated as necessary.

Q23: With the change of state reimbursing providers, will local contractors still need to execute contracts with the providers or will that activity revert to the state as well?

A23: CSP contractors will enter into written agreements with each of the participating providers in their service regions using a NYSDOH form, the "Provider Agreement". The *Provider Agreement* includes the Participating Provider Requirements as listed in the Master Grant Contract Program Specific Clauses (A-1, Part B). *Provider Agreements* will be signed by the contractor, the participating provider and the NYSDOH designee. Provider agreements will be established for the duration of the five-year grant period and updated as necessary. You can access the Master Grant Contract document within the Forms Menu of your application. Click on *Contract Document Properties*, then *view file* under Attachment A-1.

Q24: Will the state or the local contractor hold the provider credentialing contracts?

A24: CSP contractors will be required to initiate written agreements with all participating providers that offer screening and diagnostic services to CSP-eligible clients within their service region. These *Provider Agreements* are signed by the CSP contractor, the participating provider and the NYSDOH designee (See response to Question 23.) CSP contractors will also conduct participating provider credentialing at the direction of the NYSDOH. CSP contractors will

submit the names, license numbers, practice locations, and other requested information for all participating providers to ensure that they are licensed, appropriately qualified and credentialed, without restrictions, for the provision of services to CSP-eligible clients.

Q25: On the list of Performance Measures to Assess Implementation of Required Work Plan Strategies, Performance Measure #24 states: "Submit provider credentialing workbook by Dec. 31, 2018 and annually thereafter by April 1." Is that correct? Or should it read "…annually thereafter by October 1"?

A25: Initial provider credentialing workbooks are due by December 31, 2018 and annually thereafter by April 1. The annual dates may be revised throughout the five-year grant period.

Required Scope of Work and Activities/General

Q26: Will the lead agency have access to the subcontractor's data through the CSP secure, online data system (Catalyst)?

A26: Yes, each successful awardee (CSP contractor) will have access to all data for their service region through the CSP secure, online data system. Access will be granted after awards are made to the successful applicants.

Q27: Does the applicant have to screen for all three types of cancer at the onset, or can one (e.g., colorectal) be added in year #2 or year #3 of the grant period?

A27: Contractors cannot phase in screening services in this way and are expected to offer breast, cervical and colorectal cancer screening and diagnostic services to eligible populations beginning in the first contract year. As stated in the RFA, p. 11, "All transition and start up activities should be initiated beginning October 1, 2018 and completed within 90 days, no later than December 31, 2018".

Q28: RFA p. 11, III. Project Narrative/Work Plan Outcomes, B. Scope of Work, 1. Program Management and Leadership, c, Is it required to have a toll-free recruitment phone line data base? Please clarify the term "toll free recruitment phone line data base". As a current CSP we use a local telephone number and the NYSDOH CSP 1-866-442-2262 as the public contact numbers for our CSP contract.

A28: No, the CSP contractor does not need a toll-free recruitment phone line database. The Department, Bureau of Cancer Prevention and Control maintains a database listing the public contacts for the CSP and other Bureau contracts. This contact information is used on the Department's public website and is provided to the vendor that operates the Department's toll-free cancer program recruitment phone line so that potential clients can contact their local CSPs and other Bureau contractors. The Department's toll-free cancer programs recruitment phone line is the 1-866 number referenced in your question. Callers to the toll-free phone line are directly transferred to the CSP nearest them. The toll-free phone line and the Department's website are used on Department promotional materials such as digital and social media campaigns (e.g, the Department's Face Book page), paid media campaigns (television, print,

radio, etc.) and Department print materials. CSP contractors must provide the NYSDOH with the contact information for use by the toll-free line and on the NYSDOH website.

Q29: Will we be required to only voucher for infrastructure monthly?

A29: Yes. Each contractor will receive one State infrastructure contract to support personal and non-personal costs. CSP contractors are required to submit monthly claims for payment for reimbursement of approved, budgeted expenditures that reflect actual and appropriate costs, and are accompanied by necessary and sufficient back-up documentation to substantiate the costs.

Q30: Section III, B, 3: Community Needs Assessment – Is the New York State Department of Health asking partnerships to host their own Community Needs Assessment or is the assessment based on current data that is already available? Will partnerships need to submit a report of the Community Needs Assessment separate from the Targeted Outreach plan?

A30: Awardees (CSP contractors, whom were formerly referred to as 'partnerships') will not be required to conduct their own Community Needs Assessment. For the purposes of identifying priority populations and developing a written targeted outreach plan, CSP contractors will use current available data from a variety of sources including, but not limited to, existing community needs assessments that provide data and information on the current health status of CSP-eligible and priority populations in the service region. CSP contractors will not be required to submit a separate Community Needs Assessment with their written targeted outreach plan.

Provider Reimbursement

Q31: In reference to RFA p. 18, Section III.B.4, Provision of Health Services, Screening, Diagnostic and Case Management Activities, e. Provider Reimbursement, what is the process flow that will be used for State and HRI reimbursement to providers? Will providers be sending claims to the State for reimbursement?

A31: Health care providers and clinical laboratories that provide screening and diagnostic services to CSP-eligible clients (known as participating providers) will not send claims to the State for reimbursement of clinical services. Rather, the client services data that is entered in the CSP, secure, online data system will be used to generate a monthly billing report (MBR) at the beginning of each month. The MBR reflects client service data entered by CSP contractors during the previous month. The MBRs are used by the NYSDOH and HRI to directly reimburse participating providers for the provision of eligible services to CSP-eligible clients.

Participating providers must obtain a vendor ID in the State Financial System (SFS), New York State's accounting and financial management system, to receive reimbursement for State-funded services. You can find information about SFS on the State Financial System website. CSP contractors will assist participating providers to obtain Vendor ID #s in SFS as needed.

The NYSDOH will send the participating provider's contact person a password-protected email via a designated NYSDOH email account. The email will include that month's summary of State-funded patient services. The participating provider's contact will review the patient

services summary and respond with confirmation that the services were provided and are accurate. Upon receipt of that written confirmation, the NYSDOH will create an invoice in SFS to initiate payment. State payments will be made according to the method designated by the participating provider in SFS, i.e., checks will be mailed to the address designated or electronic payments will be deposited to the bank account of record.

For federally-funded services, HRI will send checks to the participating provider's contact, without prior confirmation from participating providers. The checks will include that month's summary of HRI-funded patient services.

Participating providers may receive two separate payments (State and HRI) each month, depending on the type of service provided and appropriate funding source. Regardless of State or federal fund sources, reimbursement will be made for the global (professional and technical) reimbursement directly to the one participating provider. For example, a hospital performs the mammograms and a private radiology group interprets them. The hospital represents the participating provider reported on the CSP data system and will receive full global reimbursement. The hospital must pay the technical component or negotiated rate to the private radiology group.

CSP contractors will be provided with detailed guidance and technical assistance upon award. See RFA, p. 18 for CSP contractor provider reimbursement responsibilities.

Q32: Will you kindly provide information as to how clinical services will be reimbursed with the takeover of that process please? Will the contract awardee need to pay the provider for services then voucher for reimbursement?

A32: The CSP contractor will <u>not</u> pay the provider for services then voucher for reimbursement. Instead, all screening and diagnostic services rendered to CSP-eligible clients by participating providers will be directly reimbursed by the State and Health Research, Inc. (HRI). (See response to Question 31.)

Q33: Who will be paying the providers? Please explain in more detail the payment process.

A33: The State and HRI will reimburse providers. (See responses to Questions 31 and 32.)

Q34: If the state is paying the providers, what is the timeframe in which providers will be paid?

A34: The NYSDOH and HRI will use the monthly billing reports (MBRs) that are generated by the CSP data system to directly reimburse participating providers for the provision of eligible services to CSP-eligible clients monthly. MBRs reflect client service data entered or modified by CSP contractors during the previous month. In general, NYSDOH and HRI payments for clinical services can be expected 30 days after the MBR is generated from the CSP data system. There are several factors that could impact timing of provider reimbursement, including timely data entry by CSP contractors and monthly provider confirmation of services rendered. All data must be entered and accepted on the CSP data system to be reimbursed for services rendered to CSP-eligible clients. CSP contractors are responsible for ensuring that all required data and

associated documentation (e.g., client demographics, screening and diagnostic services information, treatment information) for clients receiving services from participating providers and for whom reimbursement is requested, are collected and entered by those fulfilling the data management function in a timely manner, consistent with the NYSDOH policies and procedures, using required forms and the on-line, secure CSP data system. Providers are responsible for responding to an electronic invoice generated by the NYSDOH confirming the invoice information. Payments for NYSDOH-funded services will be delayed until the NYSDOH is in receipt of written (email) confirmation that services were provided and are accurate. (See response to Question 31.)

Q35: What are, if any, the additional responsibilities of the lead agency and the subcontractors related to provider reimbursement?

A35: CSP contractor responsibilities for provider reimbursement are listed on RFA, p. 18. CSP contractors are also responsible for timely data entry, which is used to invoice and reimburse participating providers for provision of eligible services to CSP-eligible clients.

Reimbursable Screening and Diagnostic Services

Q36: We have reviewed procedures and codes in "Attachment 3 – 2017/2018 Maximum Allowable Reimbursement Schedule (MARS)." Virtual colonoscopy procedures do not appear to be on the list. Will virtual procedures be reimbursable, and if so, what CPT codes will apply and what will the reimbursement amounts be?

A36: Virtual procedures are not reimbursable through the CSP. The CSP is a risk-based, public health cancer screening program that provides reimbursement for annual fecal testing with approved fecal immunochemical tests (FIT) or high sensitivity guaiac fecal occult blood tests (gFOBT) for eligible individuals at average risk for colorectal cancer or screening colonoscopy to CSP-eligible individuals who are determined to be at high risk for colorectal cancer. Refer to the CSP Operations Manual, Chapter 3 for additional information about CSP client eligibility. All FIT tests for which the CSP provides reimbursement must comply with guidelines for specificity and sensitivity as recommended per the United States Preventive Service Task Force or tests that have significant published data for the detection of colon cancer. See the link to the National Colorectal Round Table Clinician Reference regarding stool based tests for colorectal cancer screening at http://nccrt.org/resource/fobt-clinicians-reference-resource/. The NYSDOH requires adherence to these recommendations and will reimburse the option(s) necessary to maintain clinical standards, while using public resources to serve the greatest number of eligible clients. The CSP reimbursement criteria are not clinical guidelines. These are criteria for service reimbursement through the CSP only. Alternate funds must be identified to reimburse for services that are recommended by providers but which are not reimbursed by the CSP. The CSP does not reimburse for services billed by Current Procedural Terminology (CPT) code. The established reimbursement rate is based on Medicare regional global rates, which include the technical and professional components of the services to be reimbursed.

Required Staff and Functions

Q37: Can staff roles be split between those counties that are combined?

A37: Yes, with the exception of the Program Coordinator. The contractor is required to hire and employ a professional position for a Program Coordinator whom will serve as the coordinator for all required activities throughout the entire service region. The Coordinator will be the primary contact with the NYSDOH for this grant program. Applicants may propose staffing patterns to fulfill all other required functions and implement all required activities throughout the entire service region as they see appropriate for their service region. This may include subcontracts, consultants and partners whom fulfill one or more required functions. One appropriately qualified person may be responsible for multiple functions, but all functions should be fulfilled. Staffing patterns should be sufficient to provide required activities throughout the entire service region for the estimated CSP-eligible population with no counties within a multi-county service region left uncovered. (See RFA pp. 21-24)

Q38: RFA p. 16, Section III, B, 4, b, ii and RFA p. 22, Section III, C, 2, d– Please clarify what is considered "qualified personnel"?

A38: Section III.B.4.b.ii refers to staff that provide clinical oversight for the interpretation of client reports and medical records, determination of client eligibility, and to ensure adherence to guideline-concordant care. These staff should have the appropriate education and professional credentials and competencies to effectively interpret client reports and medical records, determine client eligibility, and to interpret clinical guidelines. Section III., C., 2., d refers to patient navigators. Patient navigators should have appropriate education and professional credentials and competencies to effectively fulfill the navigation activities as outlined in Section III, B, 5, , pp 18-20. Sample education, experience, skills and abilities for a patient navigator are provided in Attachment 6, Sample Patient Navigator Position Description. For both positions, applicants will need to determine the appropriate qualifications based on their agency's personnel practices and the appropriate level of experience and education for the proposed position within their agency and to meet the needs of their service region.

Q39: How can applicants find out how many staff work in the CSP programs in the counties that we don't currently run and are in the region we propose to cover? (Section B Scope of work, #1 Program Management, letter b, pg. 11)

A39: Applicants are encouraged to contact the current CSP contractors for their application service regions. Contact information is available on the Department of Health website at, https://www.health.ny.gov/diseases/cancer/services/community_resources/, listed by County.

Q40: How can applicants get information on the number of clients that will need to be transitioned from counties that we don't currently serve, in order to provide a sufficient staff plan? (Section B Scope of work, #1 Program Management, letter a and b) (p. 23, #3e Proposed staffing pattern)

A40: Applicants are encouraged to contact the current CSP contractors for their application service regions. Contact information is available on the Department of Health website at, https://www.health.ny.gov/diseases/cancer/services/community_resources/, listed by County. Applicants may also use the estimated eligible population information listed by service region in RFA Attachment 2, CSP Service Regions and State Infrastructure Contract Values, to estimate the populations in need of services throughout the applicant service region.

Q41: p. 21 C. Required Staff and Key Functions 1. Required Staff-Program Coordinator. In this section it says the Program Coordinator is recommended at a 1.0 full time equivalency (FTE), are there requirements or recommendations for staff time (FTE or percentage) for other key functions (Education, Case Management, Patient Navigation**,** Data Management, etc.)?

A41: There are no FTE requirements or recommendations for the other required functions. Applicants should propose staffing that they anticipate is needed and sufficient to implement all required functions throughout their entire service region to address the needs of the estimated CSP-eligible population. Applicants should propose staff, subcontractors and consultants as needed to fulfill the required staffing and functions, within the annual infrastructure contract values provided in Attachment 2. Applicants may also identify and acquire agreements from partners to fulfill required functions. See RFA, p. 24, "…partners are individuals or community organizations that have common goals and/or priority populations and agree to offer services, goods, etc. to fulfill RFA requirements at no cost (partners are not included in the application budget)."

Q42: p. 21 C. Required Staff and Key Functions 1. Required Staff-Program Coordinator and p. 23 C. 3. Other staffing requirements. d. Can the Coordinator fulfill other functions within the full-time work load (1.0 full time equivalency, FTE) for example Patient Navigation?

A42: The Coordinator may fulfill other functions within the required 1.0 FTE. For example, the Coordinator, if they are a Registered Nurse or licensed health care provider, could fulfill the clinical oversight function. It is strongly recommended that the Coordinator NOT fulfill the Patient Navigation function. Experience with this practice indicates that it does not allow either function to be fully implemented as per RFA requirements.

Patient Navigation and Patient Navigator Functions

Q43: RFA pp. 18-20, Section III, B, 5, Looking for some clarification … Many DSRIP projects include the use of Patient Navigators so these positions are being implemented in clinic offices/sites and hospitals. Is the Cancer Services Program supposed to supplement work that is already being done in offices?

A43: The CSP patient navigation work is specific to identifying individuals in priority populations who need screening and facilitating their access to breast, cervical and/or colorectal cancer screening. The CSP patient navigation work will be conducted within health care facilities that, among other criteria, are sites that have low breast, cervical and/or colorectal cancer screening rates among their patient populations and/or little to no access to patient navigation resources to address those cancer screening rates. Some DSRIP sites may meet those criteria,

some may not. The CSP contractors will target sites that need improvements, as demonstrated by the data.

Q44: Does the role of the Project (Patient) Navigator have to be a new, paid position for the CSP grant or are we able to use systems and resources that are already in place such as a Medical Home care manager?

A44: The role of the Patient Navigator does not have to be fulfilled by a new, paid, grant-funded position. Applicants may propose to fulfill required functions with new staff, existing staff, consultants, subcontracts and/or partners that have the appropriate credentials and competencies for the functions. If applicants propose to fulfill functions, such as the patient navigator function, with existing staff, systems and resources, the applicant agency must ensure that any CSP-grant-funding is not supplanting funding for existing staff, consultants or subcontracts and that the CSP-grant funding represents the time and effort for the stated work on the CSP grant and does not support work other than the CSP work. If an existing Medical Home Care Manager is currently funded 100% for Medical Home care management on another funding source and that position is then funded on the CSP grant at 50% full time equivalency, then moving forward, 50% of that staff time and effort must be devoted to CSP patient navigation to improve cancer screening rates among the patient population in the designated health system/healthcare practice. Additionally, sites for CSP patient navigation will be selected based on criteria that includes sites that have low breast, cervical and/or colorectal cancer screening rates and/or little to no access to patient navigation resources to address those cancer screening rates. If the Medical Home does not meet those criteria, it will not be an appropriate site for CSP patient navigation. If, however, it meets those criteria (and others to be identified upon contract execution), it may be appropriate to work with that Medical Home to improve cancer screening rates through the CSP contract. (See response to Questions 16, 17, 48, and 71.)

Q45: Will the template for the Patient Navigator and Evidence-based Intervention (EBI) implementation plan that is mentioned on page 19 (a) of the RFA include a mechanism to track the Patient Navigator's time and activities for reporting purposes?

A45: The template referred to on RFA p. 19 (a) will not provide a mechanism to track the Patient Navigator's time and activities. The patient navigation and EBI implementation plan template will provide a framework to plan patient navigation and EBI activities and define data collection requirements for successful fulfilment of contract requirements.

Q46: What is the percent (%) of effort (i.e. FTE or full-time equivalency) that is required for the Patient Navigator?

A46: There is no requirement for the Patient Navigator percent effort (FTE). It should be sufficient to implement the patient navigation activities as listed in the RFA, pp. 18-20, to achieve a 10% increase from baseline over the course of the five-year grant period, in: 1) the percent of women aged 50 to 74 years who had a mammogram, 2) the percent of adults aged 50 to 75 years who had appropriate screening for colorectal cancer, and 3) the percent of women aged 21 to 64 years who received one or more Pap tests to screen for cervical cancer (Program Performance Measures 27, 28 and 29). The patient navigator FTE should be appropriate for the

size of the patient population within the health care facilities in which patient navigation is implemented.

Q47: Can there be more than one patient navigator per service region?

A47: It may be appropriate to propose more than one patient navigation site and/or more than one patient navigator in a service region if there is a need, implementation capacity, available funding or other resources (e.g., partner contributions). Criteria for selection of patient navigation sites will be provided to awardees after contract execution. Among the site selection criteria are those sites that have low breast, cervical and/or colorectal cancer screening rates among their patient populations and/or little to no access to patient navigation resources to address those cancer screening rates. An example of patient navigation implementation in a region with multiple sites that meet the site criteria is, an applicant may propose to implement patient navigation within four federally qualified health center clinics, providing subcontracts to each clinic site to support .25 FTE patient navigators at each site, or, may work with one FQHC to subcontract for support of 1 FTE patient navigator.

Q48: As an PN NAPBC grantee, can any of the staff under that grant overlap to this project or is entirely separate staff required?

A48: If the PN NAPBC contractor is applying for the CSP contract, or will be a subcontractor on a CSP application from another agency, the CSP contract budget should not replace funding for the patient navigator currently funded on the NYSDOH/HRI PN NAPBC contract, this would be considered supplanting. If however, the applicant agency has existing staff that are appropriately qualified and allocated to the CSP contract without supplanting or compromising those staff's time and effort on other/current contracts, it is allowable to have some staff funded on two or more contracts. Applicants to this RFA and the NYSDOH/HRI PN NAPBC contractors are encouraged to collaborate to improve access to breast cancer screening for the underserved. Specifically, they should ensure that clients identified as in need of breast cancer screening by the NYSDOH/HRI PN NAPBC contractors that are CSP-eligible should be referred to the CSP contractors for screening services. (See responses to questions 16, 17, 44, and 72.)

Administrative Requirements/MWBE

Q49: If an applicant/contractor wishes to subcontract with municipal/nonprofit agencies which currently/previously have operated a CSP in its service region, will this be grounds to justify an M/WBE waiver request? We are in a region in which three different public and community agencies currently have CSP contracts. Since only one contract will be awarded in our region under this RFA, we are exploring options (such as subcontracting with one or more of these experienced CSP contractors) that could maintain and build upon our area's existing CSP infrastructure. If a waiver cannot be considered on the grounds outlined above, how can an applicant who wishes to build a project utilizing such subcontracting partnerships undertake "good faith" efforts to identify and solicit M/WBEs if the premise of the proposal is to subcontract with already-identified, experienced organizations?

A49: Yes, if your organization plans to subcontract with municipal/nonprofit agencies that have previously operated a CSP this is grounds for an MWBE waiver request. The language you provided regarding 'exploring options with experienced CSP subcontractors that could maintain and build upon your area's existing CSP infrastructure' should be included in the Description Box on the Utilization Plan form when a waiver is requested.

Q50: Regarding the MWBE requirement, my organization, a non-profit hospital, typically has Non-Personal Services expenses that total to under 1% of the total requested amount for this grant. The total expense for the Non-Personal Services category is low and includes only office and medical supplies. My organization has existing contracts that we must adhere to for purchasing these types of supplies from specific vendors. Are we eligible to submit a waiver for the MWBE requirement?

A50: Yes. You are eligible to submit a Form 2 Waiver Request along with Form 1 Utilization Plan, Form 4 Staffing Plan and Form 5 EEO Policy Statement. The Form 2 should document your contractual obligation to use vendor(s) that are not NYS certified Minority/Women-owned Business Entities (MWBE) for the eligible purchases.

Q51: In the pre-submission upload section, Attachment 8: If total dollar value of eligible expenditures for life of contract is zero, do we still need to complete the MWBE Utilization Plan?

A51: Yes, if your organization determines that the total eligible expenses is 0, complete the Form 1 Utilization Plan by providing a statement in the description box saying the total eligible expenses for this project is zero as the funds are being allocated towards…x, y, z. The Form 2 will also have to be completed as a Waiver Request from MWBE participation and the Form 4 Staffing Plan and Form 5 EEO Policy Statement.

Q52: Are there MWBEs interested in subcontracting?

A52: Yes. See vendors interested in subcontracting to meet the MWBE requirement:
Dependable Home Care Inc.
Website: http://www.dependablehomehealth.com
Email: dr.taylor@dependablehomehealth.com
Phone: 718-499-6066
Licensed Home Care Services certified NYS MWBE

Administrative Requirements/Healthy Meeting Guidelines and Refusal of Funds from Tobacco-Related Entities

Q53: p. 35 IV. Administrative Requirements O. Healthy Meeting Guidelines and P. Refusal of Funds from Tobacco-Related Entities. Where do we certify that we comply with the Healthy Meeting Guidelines and Refusal of Funds from Tobacco-Related Entities, is there a form to be completed and signed or should these statements be included in one of the narrative sections of the application?

A53: Certification is not required with the application, it is completed by successful RFA awardees during the contract execution process. Awardees will certify compliance with the Healthy Meeting Guidelines and Refusal of Funds from Tobacco-Related Entities by signing the resulting contract. These requirements are located in Attachment A-1: Program Specific Terms and Conditions, Part B. You can access this document within the Forms Menu of your application. Click on *Contract Document Properties,* then *view file* under Attachment A-1.

Completing the Grants Gateway Application/General

Q54: When completing the application, what should we do if there is a PDF that is larger than 10MB?

A54: Visit website, https://smallpdf.com for assistance in reducing a large file to below the 10MB threshold. If this does not resolve the issue, as an alternative, you can upload the file in the Grantee Document folder, making note in an appropriately named Attachment in the Pre-Submissions Upload folder. For example, if Attachment 15: Job Descriptions and Resumes, is too large, you may create a one-page document titled, Attachment 15: Job Descriptions and Resumes and note on that document that the file was greater than the 10MB threshold and is uploaded in the Grantee Document folder.

Q55: In the past there have been limits to each section of the proposal, i.e., no more than 1,000 words or no more than two pages, double spaced. I understand that all will be uploaded and submitted in grants gateway and this may negate the question, but are there any page or other similar limits in the proposal?

A55: Applicants will insert responses to the Application Content questions within the appropriate fields in the Grants Gateway application. Each field has character limits that cannot be exceeded. Character limits for the work plan and budget fields are provided in the instruction documents, provided as Attachments 11, 18 and 19, respectively. Applicants are advised to draft their responses to the application content questions, work plan and budget entries in a Word document so that they can determine the character count for each response using the Word Count tool, and then insert the text into the Grants Gateway application fields. This will ensure the correct character count for each response. Note that the Grants Gateway system will not generate an error message if an applicant goes over the character count; rather, the text may be cut off in the final upload/submission which may result in a reduced score.

Q56: With regards to the word limitations on the Grants Gateway: Are footnotes to be included as part of the word count?

A56: Yes. All letters and spaces drafted in response to the questions and requirements in the RFA Completing the Application section are included in the character limits for their appropriate field in the Grants Gateway application. However, footnotes may not display appropriately as the text boxes in the Grants Gateway have no formatting codes.

Q57: Whenever I cut and paste the description of a performance measure containing the greater than or equal to sign (≥), it reverts to an equal sign (=) upon saving. How do I correct this? Do I have to add a note explaining the issue each time it occurs?

A57: The "<" and ">" symbols are not accepted as entries in the Grants Gateway fields and revert to "=" when entered. You should type the text, "less than" or "greater than" instead of using the symbols. The "=" is an acceptable/working symbol in the Grants Gateway fields, so, your text could be, "greater than or = …".

Q58: When entering in the budget section of grants gateway, the line for equipment requires an entry to proceed-although the instructions specify to leave blank if no equipment is being requested. The drop-down box requires an answer of "purchase" or "rent." Please advise how to continue for this line item if no equipment is being requested.

A58: When data has previously been entered on a budget line page and then saved, the applicant can no longer leave it empty. Select "delete" at the top of the Equipment page and save.

Q59: While completing the Objectives and Tasks portion of the work plan, I noted under Targeted Outreach, what is listed as Task 2 is only a continuation of the descriptions of Task 1. The actual Task 2 is shown as "Task 3" on the form on Grants Gateway.

A59: In the Grants Gateway application, due to character limits, the additional task (2) under Objective 3 was required to allow for the continuation of text for Task 1. This resulted in an additional task (3) under Objective 3. Note the following clarification to Attachment 11, Grants Gateway CSP Work Plan Instructions, Objective 3, Targeted Outreach: The Task 2 Performance Measure Name and Narrative should be entered for Objective 3, **Task 3** in the Grants Gateway, Work Plan. Task #2 does not require entry of a Performance Measure. See the modification to Attachment 11 at the beginning of this document.

Q60: I have accidently started more applications that I intend to submit. Can I delete the ones I do not want to submit?

A60: Applications cannot be deleted. However, the application can be cancelled by changing the status to Application Cancelled using the Status Change feature.

Q61: On "Attachment 4 – CSP Performance Measures," it indicates PM 9 (Percent of eligible Population Screened) has been removed. Is that correct? Why then, on the Work Plan, Obj. 4, Provision of Health Services, Task 1, Performance Measure 3 (Clinical Services Provision), a requirement is that "greater than or equal to 15% of the eligible population screened in each county"? PM 9 would be needed to measure this.

A61: Performance Measure #9, greater than or equal to 15% of the eligible population screened in each county has been removed. See the modification to Attachment 11 at the beginning of this document.

Subcontracting

Q62: We are looking to be the subcontractor for a partner on this. What is the most appropriate way for the contractor to display this in the application?

A62: Subcontracts should be included in the NPS (Non Personal Services) Contractual Service section of the budget. Applicants should secure commitment letters from subcontractor organizations. Use Attachments 18 and 19 for application budget preparation instructions. It is recommended that applications include Letters of Collaboration for each known subcontractor. The content of these letters is described in RFA p. 40. Letters of Collaboration should be scanned and included as part of one document, titled, Attachment 16: Letters of Collaboration, and uploaded in the Pre-Submission Uploads section of the Grants Gateway application.

Letters of Collaboration and Letters from Clinical Service Providers

Q63: If a current CSP contractor is applying, and that contractor has an existing, very extensive, network of providers, is a letter of collaboration needed from every one of those providers? Or would a representative sample suffice?

A63: Letters from every one of the participating providers are not needed. A representative sample will suffice.

Q64: RFA, p. 39: Please clarify when the letters from Clinical Providers are due?

A64: Representative sample of Letters from Clinical Service Providers that demonstrate a sufficient number and type of providers offering breast, cervical and colorectal cancer screening and diagnostic services throughout the entire service region should be submitted with the application. These should include the information requested in RFA, p. 39, should be scanned into one document titled, Attachment 14: Letters from Clinical Service Providers and uploaded to the Pre-submission Uploads section of the Grants Gateway application. These may be a representative sample; letters from every provider are not required.

Q65: Is there a minimum/maximum requirement for the number of letters of collaboration from partners and clinical providers we should submit?

A65: No. The number of collaborators and clinical providers (participating providers) will be dependent on the size of the service region, the CSP-eligible population within the service region, the applicant agency and the applicant's proposed plans for collaborations to implement the CSP.

Q66: Are we required to get letters from laboratories such as Quest Diagnostics?

A66: Applicants are not required to obtain letters from any one or more specific health care provider or clinical laboratory. Rather, applicants should obtain and submit letters from a representative sample of participating providers that demonstrates a sufficient number and type

of providers offering breast, cervical and colorectal cancer screening and diagnostic services throughout the entire service region.

Q67: This question is regarding letters from clinical service providers: The RFA does not indicate if these letters must be double spaced and limited to two pages (as are the letters of collaboration). Are there any formatting or length requirements/limitations (other than the combined size of 10MB)?

A67: The letters from each clinical provider may not exceed two, double-spaced pages; any individual letters beyond that will not be reviewed. Refer to the modification listed at the beginning of this document which supersedes the RFA.

Q68: RFA p. 39, e. Technical Proposal v. Letters from Clinical Service Providers. Do we need to have letters from Clinical Service Providers (Attachment 14) from the counties which were added to our current service area in this application or is this part of the transition phase Oct.-Dec. 2018 should we be awarded the grant?

A68: The application should include a representative sample of Letters from Clinical Service Providers that demonstrate a sufficient number and type of providers offering breast, cervical and colorectal cancer screening and diagnostic services throughout the entire service region.

Q69: Located in Program Specific Questions, RFA p. 42, question h.ii, it mentions letters of collaboration from existing CSP contractors, NAPBC Patient Navigators, Mobile Mammography Vans, as well as Peer Education Outreach contractors are needed to secure additional point values. If we are a current grantee for any of the above, is a letter of collaboration required, or will we receive the extra points automatically? If a letter is required, will the New York State Department of Health provide same?

A69: Applicants should submit letters of collaboration demonstrating their ability to partner with organizations to serve the CSP-eligible and priority populations throughout their service regions. If the applicant agency receives one or more of the above-referenced contracts, a letter of support from the applicant agency committing to collaboration between each specific contract program that describes the nature of that collaboration and all other required Letters of Collaboration content is necessary to receive preference points. The Department of Health will not provide letters of collaboration for these applications; these letters should be from the organizations managing the programs that will offer the collaboration.

Budget

Q70: RFA p. 41, Section V, g, viii., bullet point 2: Ineligible Budget Items, Due to the downsizing of partnerships into the 22 service regions there has to be some consideration for staffing changes, office moves, etc… Is it reasonable to assume that items such as computers, office chairs, desks, etc will be considered approved items?

A70: This is a new, five-year grant period. Application budgets should include anticipated purchases consistent with the proposed work plan and staffing structure and the budget guidance.

While purchases of major pieces of depreciable equipment, remodeling or modification of structures are not allowable budget items, limited computer/printing equipment may be considered with appropriate justification (e.g., new staff without a computer in need of one to perform required job functions). Items such as, but not limited to, chairs and desks for staff working to complete work plan objectives and tasks may also be considered with appropriate justification.

Q71: In the webinar (Applicant Conference, February 2, 2018), it was mentioned that "match funds" were not required. Does this mean we do not have to list in-kind expenses? If we do list them, where on the application do they go?

A71: Attachment 18: Grants Gateway Budget Instructions, states, "A "match" contribution is NOT required for this grant award. Do not enter information in the match sections of the budget. For fields titled "Other Funds" always leave blank. Additional costs incurred by the program, referred to as "in-kind contributions" should be detailed under the narrative sections for the respective budget category. (i.e. In-kind staff should not be listed in the Salary Detail, but please identify any in-kind staff and the grant deliverable their work supports in the Personal Services – Salary Narrative).

Q72: Page 40 V. Completing the Application A. Application Format/Content 2. Program Specific Questions g. Budget and Justification. Please note: This funding may only be used to expand existing activities.....not be used to supplant funds for currently existing staff activities. Can you clarify this "Please note" statement?

A72: This grant funding must only support staff who are actively reporting time and effort in the performance of CSP work plan tasks and activities proposed in the new five-year grant application.

Review and Award Process

Q73: For those counties being paired up, will performance measures be a key indicator in determining which county takes on the role as the lead agency?

A73: Awards will be made to the highest scoring applicant within each service region. Scoring and award criteria are described in RFA pp. 43-45, Section V.C, Completing the Application, Review and Award Process. Application scores are based on applicant responsiveness to the questions and instructions in RFA Section V.A., Completing the Application, Application Format/Content. Current CSP contractor performance measures are not considered in the scoring process, unless they are included by the applicant in direct response to appropriate Application Content questions.